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GERIATRIC PHYSICIANS GRADUATE MEDICAL EDUCATION ACT OF 1986

HEARING

BEFORE THE

SUBCOMMITTEE ON AGING

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

ON

S. 2489

TO IMPROVE THE TRAINING OF PHYSICIANS IN GERIATRICS

JUNE 26, 1986

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GERIATRIC PHYSICIANS GRADUATE MEDICAL EDUCATION ACT OF 1986

THURSDAY, JUNE 26, 1986

U.S. SENATE,
SUBCOMMITTEE ON AGING,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee convened, pursuant to notice, at 2:45 p.m., in room SD-628, Dirksen Senate Office Building, Senator Charles E. Grassley (chairman of the subcommittee) presiding.

Present: Senators Grassley and Matsunaga.

OPENING STATEMENT OF SENATOR GRASSLEY

Senator GRASSLEY. I am Senator Chuck Grassley, chairman of the Subcommittee on Aging of the Committee on Labor and Human Resources, and my staff, I have been informed, has already told you what the problems are. I will only bring one additional one, and that is that our meeting for the Judiciary Committee has been changed from two to three; but I have also been informed that hopefully one of my very good colleagues, Senator Matsunaga, will be here to continue the hearings, so hopefully, we will not be interrupted as far as the participants are concerned, and we can expedite this then beyond where we were.

Now, I am sure that lots of you know what the purpose of the hearing is today, but let me make very clear that it is to inquire into whether we are training enough physician gerontologists and geriatricians and whether those that are being trained, as well as those who are presently in practice, have access to the most recent advances in scientific and medical understanding about older people.

The concern which prompts this subcommittee to call this hearing is not new but it is one that continues to be of major importance. It seems clear that the health care needs of older people are coming very quickly to dominate the field of medicine, and indeed our health care system generally.

According to a study done in 1980, 43 percent of patients seen by general practitioners on a typical day are between 65 and 75 years old, and 47 percent are over 75 years of age. The implication for the public sector of this increasing importance of older people to the health care system are considerable.

According to 1984 data, public funding paid for 67 percent of the total health care outlays for those over 65. The public sector paid

88 percent of the elderly's hospital bills, 48 percent of nursing home bills, and 60 percent of the bill for physicians' services.

In this context it becomes important to ask whether the preparation of our physicians, who treat older people and who make the major decisions which allocate our health care resources, pays enough attention to the special needs of the elderly.

According to at least some recent analysis, the answer is no. One assessment pointed out that the vast majority of undergraduate medical education courses in geriatrics were elective. Only 1.2 percent of the courses discovered by the survey were required. Another analysis noted that although nearly 75 percent of the medical schools in the United States offer elective courses in geriatrics, only 4 percent of the medical students take them.

Finally, and of utmost importance to our concerns before this subcommittee this very day, there are less than 400 geriatric teachers available today; yet we have more than 800 residency training programs which each require at least two geriatricians to teach future physicians of the elderly.

In order to get a better picture of the situation with respect to medical education in geriatrics, we will take testimony on a number of more specific questions. These will deal with, first of all, do older people differ from younger people in ways that have implications for medical practice, and is there a body of knowledge about these differences. Second, if there are differences, do they have implications for the training of medical practitioners? Third, what is the present and near-term future availability of appropriately trained medical personnel? And fourth, what are feasible and reasonable ways to train additional numbers of such physicians, should that be deemed necessary?

Some of the witnesses will also comment on a bill, S. 2489, which is designed to make a modest contribution to improving the education in geriatrics of primary care physicians. This bill was introduced by Senator Kennedy with Senators Heinz, Metzenbaum, Glenn, Rockefeller, and myself.

The bill would amend section 788 of the Public Health Service Act. The bill makes available an additional $4 million for the purpose of expanding present programs and creating new programs to train physicians who plan to teach geriatric medicine.

It is the hope of the sponsors that if passed into law, this program would produce an additional 900 physicians by the year 1992, appropriately trained to teach our residents and practicing physicians the essentials of geriatrics.

It is important to point out that it is not the intention of this bill to contribute to the development of a geriatrics specialty; rather, the idea is to provide quality training in geriatrics to primary care physicians who will be called on to work with older patients in the future.

Neither is the bill designed to produce additional physicians. The purpose is rather to increase the amount of training devoted to the special needs of the elderly.

Finally, the funding level for the program envisioned is modest but appropriate, given our present concerns about the Federal budget deficit.

At this point we will receive for the record the opening statements of Senators Matsunaga and Metzenbaum and prepared statements by Senators Heinz and Glenn.

[The statements referred to follow:]

OPENING STATEMENT OF SENATOR SPARK MATSUNAGA

Senator MATSUNAGA. Thank you, Mr. Chairman. As a cosponsor of S. 2489 and S. 1100, I appreciate having this opportunity to express my support for legislation to increase opportunities for education and training in geriatrics and gerontology.

The need for improvements in geriatric and gerontological education and training is self-evident to those who keep up with demographics. In 1900, only 4 percent of the U.S. population was aged 65 or older, while those aged less than 19 years made up 44 percent of the population. By 1980, the proportion of people aged 65 years and over had increased to 11 percent and it is expected to reach 20 percent early in the 21st century. This is due in part to improvements in health care, nutrition and our environment, but it also reflects the baby boom of the period immediately prior to 1920 and that immediately following World War II.

It is perhaps even more significant that the fastest growing segment of the U.S. population is represented by those aged 80 years and over. By the year 2000, it is estimated that one half of the elderly population will be over age 75, and the remaining half aged 65 to 75. It is interesting to note that, today, over 200 people in this country celebrate their 100th birthday every week.

In eastern cultures, such as Japan and China, age is venerated and the elderly are regarded as repositories of wisdom. In the West, and perhaps especially in the United States, which has always regarded itself as a young country, just the opposite is often true. We celebrate the youth culture and the old are often isolated and forgotten. While previous Congresses have examined this problem—enacting the Older Americans Act and Medicare, for example—much remains to be done if we are to address adequately the needs of the growing numbers of older Americans. Meeting the need for more specialists in gerontology and geriatrics is an excellent way to start, and, as the ranking minority member of this subcommittee, I welcome the views of the witnesses testifying today. Thank you.

OPENING STATEMENT OF SENATOR METZENBAUM

Senator METZENBAUM. Mr. Chairman, I wish to commend you for holding this hearing so important to the future well-being of all of us. I've been pleased to join with you and Senators Kennedy, Heinz, and Glenn in sponsoring the Geriatric Physicians Graduate Medical Education Act of 1986.

I believe we are all aware of the need to prepare for the graying of America. In just 35 years, over 13 percent of the population will be over 65, including all of us. In just 15 years, the over 85 group will more than double, and that includes some of us. So, it's encouraging to see this focus on national policy that pays attention to the demographic changes in our future.

We've learned that, currently, fewer than 100 geriatricians are being produced nationwide each year, and there are fewer than 400 faculty-level geriatricians available to staff the 800 residency training programs in internal medicine and family practice. And yet, it seems self-evident that every physician who cares for adults should know about the diagnosis and treatment of the diseases—the physical and mental disabilities—to which the elderly may be especially vulnerable, and should know about elderly patient management.

I take great pride in my home State, Ohio, which is in the forefront of support to its medical schools for offices of geriatric medicine.

Almost a decade ago, the Ohio General Assembly passed legislation to establish a budget line item for this purpose. Ohio's experience provides a useful model for geriatric education nationally.

Alzheimer's disease has long been a concern of mine. In the last few years, I have sponsored several bills to address problems related to Alzheimer's disease. Certainly, there is no question that an increasingly older population will require that primary care physicians be educated and skilled in strategies for maintaining quality of life throughout the extended years of life.

We all hope for more years in our life, but we also hope for more life in our years. Good preventive care, good medical care should add a better quality of life to our extended life span.

I strongly support S. 2489, The Geriatric Physicians Graduate Medical Education Act of 1986. It is an important step forward to the ultimate goal of training the faculty needed as educators in geriatrics for other relevant health professions, as well.

I look forward to the testimony of these knowledgeable witnesses, so that we can better determine the medical treatment needs of the elderly, and reasonable ways to train the additional numbers of geriatric physicians that will be needed.

STATEMENT BY SENATOR JOHN HEINZ

Before the Aging Subcommittee, Labor and Human Resources Committee

Good Afternoon. Today we are here to consider a modest but timely investment that is critical to this Nation's ability to care for a greying society: the training of physicians in geriatric medicine.

Older Americans in their 70s, 80s, and 90s represent the fastest growing segment of our population and the heaviest users of our health care system. Yet we are woefully ill-prepared to handle the special challenges of caring for these older patients. In testimony before the Special Committee on Aging, experts have told me that physicians are not trained to cope with the multiple and complex medical problems typical among the elderly. This type of innocent ignorance can lead to drug misuse, misdiagnosis and even death. Unless we act now, severe shortages of properly trained physicians could lead to widespread and unwarranted malpractice wrought on the elderly.

Today very few practicing physicians and an equally small number of medical students are trained in geriatric medicine. Out of the 520,000 doctors nationwide, only 922 are geriatric physicians. By 1990 -- only four years away -- a National Institute on Aging study

estimates we will need nearly nine times that number to care for the growing number of aged patients.

Our lack of practitioners stems from a critical lack of faculty able to train medical students in geriatrics. According to the same NIA report, we will need a minimum of 900 additional geriatric faculty before the year 2000. The bill before you, the Geriatric Physicians Graduate Education Act of 1986, would provide the financial support needed to train physicians as educators in the specialty of geriatrics in order to meet the NIA goal. Specifically, the bill would fund three training programs: one-year of geriatric training for mid-career academic physicians; and one- and two-year geriatric training for medical students specializing in family and general medicine who have expressed an interest in teaching.

The bill under consideration is one of a series of prescriptions which have been written to address the shortage of health care personnel with geriatric training. Earlier this year I fought to protect geriatric training from cuts in Medicare funding for graduate medical education in the Consolidated Omnibus Budget Reconciliation Act. Last fall, we passed the Health Research Extension Act, calling on the Secretary of Health and Human Services to recommend how specific numbers and types of health personnel can be trained over the next four decades to care for the elderly.

While Congress looks forward to hearing from HHS next spring, we should not hesitate to take action now on the measure before us.

For a small investment of $4 million a year, this bill will yield compounded interest by educating hundreds of faculty, who, in turn, will train thousands of medical students to care for our aging Nation. That's a deal we can't afford to pass up.

SENATOR JOHN GLENN

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STATEMENT OF SENATOR JOHN GLENN

AT A HEARING OF THE

LABOR AND HUMAN RESOURCES SUBCOMMITTEE ON AGING

Mr. Chairman, as the senior Democratic member of the Senate Special Committee on Aging, I am pleased to have this opportunity to add my strong support for S. 2489, the Geriatric Physicians Graduate Medical Education Act of 1986. I was pleased to join you in introducing this legislation because I believe it represents an important step toward insuring that our nation's health care providers are adequately trained in geriatric medicine.

However, before I make my case for S. 2489, I would like to commend you and Senator Kennedy for bringing Committee attention to this important bill. All too frequently, we in the Senate see meritorious legislation languish, without action and sometimes without reason, in committee. Your hearing today is particularly noteworthy because it makes it possible that S. 2489 will gain congressional approval before the 99th Congress adjourns.

The need for legislation like S. 2489 should be obvious. We all know our population is aging and we all should know that it is time for us to plan for these demographic changes. By the year 2025, 20 percent of our population will be over 65. Understanding this and keeping in mind that the largest percentage of the U.S. health care dollar is spent on the health needs of older Americans, simple common sense dictates that we make sure the providers taking care of our elderly are sufficiently trained in geriatric medicine.

The current critical shortage of trained health care professionals was fully documented in the 1984 National Institute on Aging "Report on Education and Training in Geriatrics and Gerontology." This report pointed out that a growing demand for hospital, long-term care and community services will clearly accompany the demographic changes in the elderly population.

Currently there are fewer than 400 faculty level geriatricians available to staff more than 800 training programs in Internal Medicine and Family Practice. S. 2489 provides incentives (through faculty support) to expand current geriatric fellowship programs and to develop new programs. This approach should provide, within

five years, a sufficient number of trained faculty members to staff all Internal Medicine and Family Practice residency training programs across the country.

Preparing now to have adequately trained personnel in the health care field is good public policy, not only because it is humane, but because it will also prove to be cost-effective in terms of diagnosis, treatment, and prevention. Without adequate research and trained practitioners, we cannot expect the medical and technological breakthroughs needed to combat the various diseases and conditions that particularly affect the elderly, such as Alzheimer's disease and other dementias, arthritis, osteoporosis, coronary heart disease, hypertension, and cancer. Not only are these conditions devastating to the affected individual and his or her family and friends, but they are costly to each and everyone of us.

I view the Geriatric Physicians Graduate Medical Education Act of 1986 as a first step up the ladder of success toward adequately training the health care providers who will be responsible for taking care of our ever-increasing elderly population. This bill is important in that it addresses the weaknesses we currently face in the Internal Medicine and Family Practice field. However, it does not address the shortages of faculty adequately trained in geriatrics and gerontology who teach our nurses, geriatric dentists, social workers, occupational therapists, optometrists, pharmacists, podiatrists, respiratory therapists, and who would encourage researchers to concentrate on the biomedical, behavioral, and social problems of the elderly.

Last year, I joined Senator Heinz in introducing S. 1100, the Geriatric Research, Education, and Training Act of 1985 (GREAT), which provides for a much more comprehensive framework to address our shortages in these other fields. Although it appears unlikely that Congress will act on the GREAT bill this year, I remain committed to this legislation and will continue to work for its passage. However, I cannot and will not wait around for action on S. 1100. Therefore, I am strongly supporting S. 2489 as a more modest, but necessary, first step.

I am proud to say that my home State of Ohio was the first State to provide financial support to each of its seven medical schools to establish offices of geriatric medicine. In 1977, the Ohio General Assembly enacted legislation which established a separate line item in the higher education budget to do this. Funding has risen from $350,000 in fiscal year 1979 to $1.27 million in fiscal year 1986. This experience has provided us with numerous innovative approaches to educating medical students and practitioners about the needs of elderly patients and has stimulated exciting new research.

The Congress can provide the leadership to ensure that Ohio's innovations in geriatric education are possible on a national basis. This experience needs to be replicated throughout the country if we hope to overcome the well-documented shortages of adequately prepared health care professionals to meet the challenge of our rapidly growing aging population. I believe that the Geriatric Physicians Medical Education Act of 1986 will help us meet this challenge head-on and I would hope that today's hearing represents the Senate's first step towards assuring its passage this year.

Senator GRASSLEY. I will now go to the introduction of the panel. We are going to first hear from Mr. Thomas Hatch, who is Director of the Bureau of Health Professions of the Health Resources and Services Administration. Mr. Hatch will be followed by Dr. T. Franklin Williams, who is the Director of the National Institute on Aging of the National Institutes of Health.

I thank you very much for being patient, as I have already said, and would ask that you would start out, Mr. Hatch, and then go to Dr. Williams, and then we will have questioning at the end.

STATEMENT OF THOMAS D. HATCH, DIRECTOR, BUREAU OF HEALTH PROFESSIONS, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND DR. T. FRANKLIN WILLIAMS, DIRECTOR, NATIONAL INSTITUTE ON AGING, NATIONAL INSTITUTES OF HEALTH, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. HATCH. Thank you, Mr. Chairman. With your permission, in the interest of time, I will ask that my prepared statement be entered in the record, and I will abbreviate it in order that we can move on to the other statements.

Senator GRASSLEY. Yes, it will be included in the record as submitted.

Mr. HATCH. I am pleased to be here today to discuss geriatric and gerontological education and training needs of the Nation's health work force, and in particular, physicians. I am most pleased to be accompanied by Dr. T. Franklin Williams, Director of the National Institute on Aging.

During the last several years, a variety of support for training in geriatric medicine has been provided through the authorities of title VII and title VIII of the Public Health Service Act. This support has been channeled through broad program authorities under these titles and, since 1983, through targeted support for geriatric education centers funded under section 788 of the Public Health Service Act.

The primary care training authorities encourage geriatric training through medical residency training programs and faculty development programs in family medicine and general internal medicine.

More targeted support for geriatric training is provided through section 788. Under this section, 20 geriatric education centers are presently funded to provide a comprehensive range of training within specific geographic areas. All 20 centers involve the improvement of geriatric training in schools of medicine.

By September 1986, we expect that approximately 4,700 individuals will have received training ranging from one-on-one clinical experiences of 6 months' duration to attendance at short-term continuing education seminars. These individuals include physicians, among others.

In working with the National Institute on Aging in the development of the February 1984 Congressional Report on Education and Training in Geriatrics and Gerontology, the committee of Federal representatives and its expert consultants recognized the need for

faculty development and attempted to quantify faculty targets for the years 1990 and 2000. Dr. Williams will describe that effort.

Fellowship programs funded through the Veterans' Administration, the National Institute on Aging, and the National Institute of Mental Health are producing between 100 to 140 clinical and basic science faculty per year, with about 70 percent continuing in full-time geriatric academic positions.

We believe the shortfall in geriatric faculty is lessening as we move closer to 1990. We would also point out that the private sector interest, particularly foundations, in this area, is growing, as is that in the medical community itself.

It is believed that the combination of existing programs, including a new reimbursement incentive included in the Consolidated Omnibus Budget Reconciliation Act, which provides a special 2-year exception for individuals in geriatric fellowships, the numerous private sector intiatives, the building of momentum for change within the medical community, and a likely increase in State and local government interest in this area, will result in a shift of additional resources toward the preparation of physicians and other health professionals to provide necessary services.

Thank you.

Senator GRASSLEY. Thank you, Mr. Hatch.

[The prepared statement of Mr. Hatch and responses to questions submitted by Senator Grassley follow:]

STATEMENT
BY

THOMAS D. HATCH

DIRECTOR, BUREAU OF HEALTH PROFESSIONS
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

SUBCOMMITTEE ON AGING
COMMITTEE ON LABOR AND HUMAN RESOURCES
U.S. SENATE

Thursday, June 26, 1986

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss geriatric and gerontological education and training needs of the Nation's health work force, and in particular, physicians. I am most pleased to be accompanied by Dr. T. Franklin Williams, Director of the National Institute on Aging.

During the last several years, a variety of support for training in geriatric medicine has been provided through the authorities of Title VII and Title VIII of the PHS Act. This support has been channeled through broad program authorities under these Titles and, since 1983, through targeted support for geriatric education centers funded under Section 788 of the PHS Act.

The primary care training authorities encourage geriatric training through medical residency training programs and faculty development programs in Family Medicine and General Internal Medicine as well as the Area Health Education Centers program. In FY 1985, about half of the 383 accredited graduate programs in family medicine were funded by the Bureau of Health Professions. Of this number, 72, or approximately 50%, used some funding to provide geriatric training. (This represents about 25% of the family medicine graduate programs nationwide.) A sizable number of Family Medicine grant awards for residency training and faculty development also utilized a portion of the funding for training in geriatrics. Of 91 awards in FY 1985 for General Internal Medicine/General Pediatrics Residency programs (some are joint), 38 grantees provided some geriatric medicine

training to an estimated 190 residents. Six faculty received geriatric training under the General Internal Medicine Faculty Development Grant Program. (An estimated 72 faculty were supported by the grant program in FY 1985.)

More targeted support for geriatric training is provided through Section 788. Under this section, 20 geriatric education centers are presently funded to provide a comprehensive range of training within specific geographic areas. These centers provide training opportunities in geriatrics and gerontology for faculty of medical and osteopathic and other health professions schools. They include multidisciplinary consultation and assistance in geriatric curriculum development as well as support for continuing education. All 20 centers involve the improvement of geriatric training in schools of medicine. The majority of centers also involve nursing, dentistry, pharmacy, social work, occupational therapy and physical therapy. By September 1986, approximately 4,700 individuals will have received geriatric training, ranging from one-on-one clinical experiences of 6 months duration to attendance at short-term continuing education seminars.

The Title VII authority specifically allows support for the training and retraining of faculty to provide instruction in the treatment of health problems of elderly individuals.

In working with the National Institute on Aging in the development of the

February 1984 Congressional Report on Education and Training in Geriatrics and Gerontology, the committee of Federal representatives (including HRSA) and its expert consultants recognized the need for faculty development and attempted to quantify faculty targets for the years 1990 and 2000. Dr. Williams will describe the entire effort in more detail, as well as a congressionally mandated study now underway to determine personnel needed to meet the health needs of elderly Americans through the year 2020.

There have been several attempts to estimate the number of faculty teaching gerontology and geriatrics in health professions schools. While most medical schools (91 percent) have indicated that they have training programs in aging or geriatrics, these programs vary enormously, ranging from comprehensive campus-wide programs to a single part-time faculty member. Data obtained in preparing the DHHS report indicate that there are fewer than 300 medical school faculty members or about 2.5 full-time faculty equivalents per school. A recent survey of the members of the American Geriatrics Society and the Clinical Medicine Section of the Gerontological Society of America confirmed that no more than 250 to 300 faculty members in U.S. medical schools have a major commitment to the field of geriatrics.

It has been suggested that 9 or 10 clinical faculty and the same number of basic science faculty are necessary for an integrated clinical care, teaching, and research program in geriatrics and gerontology for medical

students and house staff. Fellowship programs funded through the Veterans Administration, National Institute on Aging and National Institute of Mental Health are producing between 100-140 clinical and basic science faculty per year with about 70% continuing in full-time geriatric academic positions. So the short-fall in geriatric faculty is lessening as we move closer to 1990.

In keeping with one of the recommendations of the Report to Congress, that the Department increase training in this area by strengthening existing programs, the NIA has introduced several new approaches. Dr. Williams will elaborate on those activities.

In terms of other related activities at the Federal level, the Veterans Administration is presently supporting 50 physician fellows in geriatrics. Post-residency physicians with backgrounds in internal medicine and other appropriate specialties (family practice, neurology, psychiatry, physical medicine and rehabilitation) participate in a 2-year clinical/educational/research program providing specialized training in geriatric medicine. Since its inception in 1978-79, 128 fellows have graduated. About 90% continue to practice geriatric medicine and more than 70% hold academic appointments.

In FY 1986, post-doctoral training within the NIMH includes an estimated 12 Geriatric Mental Health Awards, facilitating career reorientation for psychiatrist faculty interested in developing more of a research focus within their department or school. A number of clinical training programs in mental health and aging emphasize postgraduate specialty

training through faculty development and fellowships, further increasing the pool of potential faculty members. It is estimated that about 36 physicians will complete such training.

Over the past several years, the Administration on Aging has funded eleven Long-Term Care Gerontology Centers to assist in the development of a continuum of care, particularly community-based care, for older persons in need of such services. Some of the Centers have developed, supported and strengthened various geriatric training programs in medicine and psychiatry.

We would also point out that private sector interest in this area is growing. Pfizer Pharmaceuticals, with cosponsorship of the American Geriatrics Society, recently awarded geriatric medicine fellowships for up to two years of clinical and research training. The Brookdale Foundation has awarded research fellowships in the field of aging. The Hartford Foundation has initiated a program of geriatric faculty development awards geared to retraining existing medical school faculty.

The medical profession itself is increasingly responding to the geriatric imperative. The Federated Council for Internal Medicine has recently acknowledged deficiencies in residency training in geriatric medicine and made recommendations for improvement. The American Geriatrics Society has drafted Guidelines for Fellowship Training Programs in Geriatric Medicine for submission to the Residency Review Committee for Internal Medicine of the Accreditation Council for GME.

It is believed that the combination of existing programs, a new reimbursement incentive included in COBRA (which provides a special 2-year exception for individuals in geriatric fellowships), the numerous private sector initiatives, a building momentum for change within the medical education community, and a likely increase in State/local government interest in this area will result in a shift of additional resources toward the preparation of physicians and other health professionals to provide necessary services.

I would like to ask Dr. Williams to present his comments now, after which we will be happy to answer your questions.

Responses by Thomas Hatch
to Additional Questions from Senator Grassley

Question. As I noted in my opening statement, around 43 percent of the individuals seen by general practice physicians on any day are between 65 and 74 and 47 percent are over 75 years of age. This information is from a 1980 article by Kane and others. This seems to imply that the typical primary care physician should know a lot about the special medical needs of the elderly. Would you agree with this statement?

Answer. Yes, I would agree.

Question. Would you agree with the point which will be made by subsequent witnesses to the effect that we should not create a geriatrics sub-specialty, but rather that every primary care physician who has a substantial percentage of older persons in his or her practice should have comprehensive training in geriatrics?

Answer. Decisions with respect to the establishment of new specialties or sub-specialties are made within the medical profession. I understand that the American Board of Internal Medicine and the American Board of Family Practice are both moving toward certification of competency in geriatric medicine, rather than the establishment of a formal sub-specialty. I certainly agree that every primary care physician should be competent to deal with the special problems of older people.

Question. In order to do this, is it not important to have teaching faculty in sufficient numbers to teach medical students and primary care

residents, the essentials of geriatrics?

Answer. Yes, it is important to have sufficient faculty to teach medical students and primary care residents the essentials of geriatrics. This need was documented in the Report on Education and Training in Geriatrics and Gerontology, submitted by the Department in 1984.

Question. How many academic geriatricians would you say we need by, say 1990? Does the Department have any official estimates or goals with respect to this?

Answer. The 1984 Report on Education and Training in Geriatrics and Gerontology set a minimum target of 600 physician faculty prepared to teach geriatrics, as a primary commitment, in U.S. medical schools by the year 1990. The target for the year 2000 is 1,300 physician faculty. These estimates relate to the basic or undergraduate level of physician education, although some overlap of faculty who teach undergraduate medical students and primary care residents may be presumed.

Question. You point out in your testimony that at present there are fewer than 300 medical school faculty members who have a major commitment to the field of geriatrics. As you know, there are about 800 separate training programs for these primary care physicians who will be taking care of older adults. Given these numbers would you agree that there is a shortage of geriatric teaching faculty at the present time?

Answer. I would agree that there is a shortage of faculty to teach geriatrics. The Report on Education and Training in Geriatrics and

Gerontology indicated that there are too few teachers with geriatric expertise who can teach future physician providers and it proposed increased emphasis on expanding the number of faculty with expertise in geriatrics and gerontology.

Question. In your statement, you reviewed some of the recent developments which indicate that more physician geriatricians should be produced in coming years. Is your position that sufficient teaching faculty will be created by these activities in an appropriate period of time? I don't believe you made a categorical statement about that in your remarks.

Answer. As I indicated in my statement, progress is being made toward attainment of the minimum targets for 1990 and 2000. Fellowship programs funded through the Veterans Administration, National Institute on Aging and National Institute of Mental Health are producing between 100-140 clinical and basic science faculty per year, with about 70% (70-98) continuing in full-time geriatric academic positions. If the current emphasis on the need for geriatric faculty continues, we believe significant progress toward meeting these goals can be made, through the above programs as well as through increasing non-federal support.

Question. Does the Department have estimates of the number of teaching faculty which will be created by the activities to which you referred in your testimony?

Answer. In terms of the Title VII primary care training authorities, as I pointed out in my testimony, geriatric training is encouraged as part of Family Medicine and General Internal Medicine faculty development

programs.

With respect to the Geriatric Education Center Program that I described in my testimony, approximately 4,700 individuals will, by the end of FY 1986, have received training since the inception of the program in FY 1983. Of these, approximately 3,000 are expected to serve as faculty of health professions education programs or have significant in-service training responsibilities. The nature of this training, as I pointed out in my testimony, is variable in length and intensity. It is, essentially, a tailored faculty development effort, often using multiple approaches to accommodate the availability of faculty in certain geographic areas. To the extent that training experiences are open to practitioners, residents, fellows, and graduate students, as well as to existing faculty, they attract some individuals who are entirely new health professions teaching faculty. The primary emphasis, however, is on the development or enhancement of geriatric teaching capabilities of existing health professions faculty and in-service trainers who need and want strengthening in this area.

Question. How much of the total appropriation for section 788 goes for faculty training and retraining as mentioned in subsection (d)(1)(D)?

Answer. In FY 1986, approximately $6.4 million of the $8 million appropriated under Section 788 will be awarded to Geriatric Education Centers. Faculty developmment, which encompasses training and retraining, occurs within each of the centers, but amounts for this purpose are not separately budgeted and are closely linked to other purposes mentioned in Section 788(d). However, in FY 1986 we estimate that about 60%, or $3.8 million, of grant funds will be utilized to

support faculty training or retraining for medicine, nursing, and other health professions.

Question. Could you be specific as to how this money is used?

Answer. Funds for the Geriatric Education Centers are used to provide a comprehensive range of educational services within targeted geographic areas including:

(1) training of health professions school faculty in geriatrics and gerontology.

(2) geriatric curriculum consultation and related assistance to health professions training programs.

(3) other educational services such as continuing education for practitioners and educational information referral systems.

The pooling of resources in geriatrics education is emphasized. A total of about 155 academic institutions and other organizations are directly affiliated with the 20 Geriatric Education Centers.

A variety of different approaches to faculty development have been employed, but the common goal is to stimulate a ripple effect by enhancing the geriatric knowledge and skills of existing health professions faculty or by training practicing professionals who are in a position to introduce geriatric content into health professions education programs. A key element is to make training available through centers with special expertise and resources in geriatrics, and follow this up with technical assistance and teaching materials provided by the center to the faculty at their home schools.

Question. How many new geriatric faculty does this support result

in, in any given year?

Answer. I would again point out that the programs of our Geriatric Education Centers utilize a variety of approaches to faculty development, with emphasis on enhancement and retraining of existing faculty. With the expansion of the Geriatric Education Center Program in FY 1985 from four to 20 centers, we expect that some significant number of faculty each year will participate in educational experiences to better prepare them to teach geriatrics.

Senator GRASSLEY. Now, Dr. Williams, please.

Dr. WILLIAMS. Thank you, Senator Grassley. I too would like to submit my written testimony for the record and will summarize here.

Our success in responding to the health care needs of the rapidly growing numbers of older people will depend upon our ability to develop a critical mass of teachers and investigators in the emerging disciplines of geriatrics and gerontology.

The need for more individuals trained in these fields has been highlighted in studies and reports by the Institute of Medicine, the Association of American Medical Colleges, and more recently, the New York Academy of Medicine.

As noted by Mr. Hatch, in 1983 the House Committee on Appropriations directed the Department of Health and Human Services to submit a plan to improve and expand training in geriatrics and gerontology. I will review here some of the highlights of the report that was submitted in response to that directive and describe some of the new initiatives being developed by the National Institute on Aging as part of this response.

In the near future, the majority of all users of health and health-related services, with the obvious exceptions of obstetric and pediatric care, will be individuals over the age of 65. Better trained professional and supportive personnel are needed to provide services to the older citizen more effectively and economically. In addition, the training of a new generation of gerontological and geriatric research investigators will help assure the more rapid development of new preventive and therapeutic approaches to age-associated disease and disorders.

The anticipated escalation of health care costs related to our increasingly aged population can be most effectively reduced by extending the healthy years of life and decreasing the years of disease and disability through medical research.

Because of the wide scope of both gerontology and geriatrics, education, and training initiatives in these fields should be targeted toward almost all health and human services professionals and allied personnel. Students entering all health professional fields must acquire a basic knowledge of the aging process and factors which appear to influence it. The knowledge base in gerontology is expanding rapidly, and a sufficient body of information is ready for dissemination.

How many faculty presently teach gerontology and geriatrics in health professional schools? While most schools have indicated that they have training programs in these fields, the programs vary enormously, ranging from comprehensive, campuswide programs to a single part-time faculty member. Data obtained in preparing our report indicate that there are fewer than 300 medical school faculty members, or about an average of 2.5 full-time faculty equivalents per school. This is clearly inadequate.

It has been suggested that 9 or 10 clinical faculty and the same number of basic science faculty are necessary for an integrated clinical care, teaching, and research program in geriatrics and gerontology. At present, the National Institute on Aging, the National Institute of Mental Health, and the Veterans' Administration are

training between 100 and 140 new individuals per year; others are being trained through other mechanisms in our country.

The Nation needs to expand efforts to create the geriatric faculty to meet these needs. The academic community, along with the private sector, needs to share responsibility with the Federal, State, and local governments to reach these goals.

How can we train sufficient faculty for educational and training programs in geriatrics and gerontology? Our Institute, the National Institute on Aging, has responded with several new approaches, including the Geriatric Leadership Academic Award—a grant program to support senior faculty who will provide leadership in stimulating and guiding the development of programs for research and training in geriatrics and gerontology. This initiative is specifically targeted to those institutions which currently do not have extensive programs in aging.

In addition, we have added awards for fellowship positions to existing training programs where we can take advantage of established training programs to train more people with an orientation toward leadership in aging and geriatrics. There are also a number of other types of support utilized by the NIA which are described in my written testimony.

The DHHS Committee which made this report in 1984 is continuing to work together to foster these efforts and is presently addressing the congressional requirement to report by next year on personnel needs for health care of older people out to the year 2020.

It is timely also for the private sector to contribute to this important endeavor. Foundations such as the Hartford Foundation, the Kaiser Family Foundation, and the Brookdale Foundation either have funded or plan to fund a limited number of fellowship positions. It is particularly pleasing to see private industry, like the Travelers Insurance Co., and the Pfizer Corp. also entering this field.

We certainly look forward to joint participation in trying to meet these needs.

Thank you.

[The prepared statement of Dr. Williams and responses to questions submitted by Senator Grassley follow:]

STATEMENT BY

T. FRANKLIN WILLIAMS, M.D.
DIRECTOR

NATIONAL INSTITUTE ON AGING
NATIONAL INSTITUTES OF HEALTH
PUBLIC HEALTH SERVICE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

U.S. SENATE SUBCOMMITTEE ON AGING
SENATE LABOR AND HUMAN RESOURCES COMMITTEE

JUNE 26, 1986

Mr. Chairman and Members of the Committee, I am Dr. T. Franklin Williams, Director of the National Institute on Aging (NIA), National Institutes of Health. I thank you for the opportunity to present information relating to geriatric training. This testimony has been modified from an article by Edward L. Schneider, M.D., and me which appeared in the Annals of Internal Medicine.

Within a very few years the health care needs of older people will dominate the field of medicine. Our success in responding to this situation will depend upon our ability to develop a critical mass of teachers and investigators in the emerging disciplines of geriatrics and gerontology. The need for more individuals trained in these fields has been highlighted in studies and reports by the Institute of Medicine, the American Association of Medical Colleges and, more recently, the New York Academy of Medicine, which devoted its 11th Symposium on Medical Education to "The Geriatric Medical Education Imperative."

In 1983, the House Committee on Appropriations directed the Department of Health and Human Services (DHHS) to submit a plan to improve and expand training in geriatrics and gerontology. In response, the Department established an ad hoc Committee on Enhancement of Training in Geriatrics and Gerontology with representation from those Federal agencies with training responsibilities in the field of aging. In February 1984, the Committee submitted its report to Congress. I will review some of the highlights of this report, as well as those from the recent New

York Academy of Medicine Symposium, and describe some of the new initiatives developed by the National Institute on Aging (NIA).

By the year 2020, when the baby boom generation in the United States enters the older age ranges, as many as 60 million Americans may be over the age of 65. Of even greater importance is the growth in numbers of the "oldest old"--the population over age 85. This is the fastest growing age cohort in America, a cohort whose numbers will more than double in the next 15 years. These demographic changes are being experienced by all other developed nations; furthermore, they will be realized far more dramatically by the world's developing nations. This shift in the composition of the population will result in increased demands for hospital, long-term care, and community services in all nations. In the near future, the majority of all users of health and health-related services, with the obvious exceptions of obstetric and pediatric care, will be individuals over the age of 65. Better trained professional and supportive personnel will be needed to provide these services effectively and economically. In addition, the training of a new generation of gerontological and geriatric research investigators will help assure the more rapid development of new preventive and therapeutic approaches to age-associated diseases and disorders. The anticipated escalation of health care costs related to our increasingly aged population can most effectively be reduced by extending the healthy years of life and decreasing the years of disease and disability through medical research.

We should distinguish between gerontology and geriatrics. Gerontology encompasses the wide range of studies of aging from biological investigations at the molecular level to socioeconomic studies of the impact of retirement on health and social status. Geriatrics encompasses clinical studies of the diseases and disabilities of older people and includes aspects of most clinical disciplines, including internal medicine, neurology, psychiatry, urology, orthopedics, family practice, nursing, and dentistry. Because of the wide scope of both gerontology and geriatrics, educational and training initiatives in these fields should be targeted toward almost all health and human service professionals and allied personnel. The multidisciplinary nature of both gerontology and geriatrics lends itself to interdisciplinary training and educational programs. Students of medicine, dentistry, social work, and nursing can all benefit by being exposed to other disciplines in the management of the older patient.

The DHHS report as well as other studies has concluded that these educational activities should be conducted at all levels including basic, graduate, and continuing education. Students entering all professional fields of health and human services should acquire, first, basic knowledge of the aging process and factors which appear to influence it. The knowledge base in gerontology is expanding rapidly, and a sufficient body of information is ready for dissemination.

How many faculty presently teach gerontology and geriatrics in health professional schools? As the DHHS report related, there

have been several attempts to estimate the number of faculty involved in educational programs in aging. While most medical schools (91 percent) have indicated that they have training programs in aging or geriatrics, these programs vary enormously, ranging from comprehensive campus-wide programs to a single part-time faculty member. Data obtained in preparing the DHHS report indicate that there are fewer than 300 medical school faculty members or about 2.5 full-time faculty equivalents per school. This clearly is inadequate. A recent survey of the members of the American Geriatrics Society and the Clinical Medicine Section of the Gerontological Society of America confirmed that no more than 250 to 300 faculty members in U.S. medical schools have a major commitment to the field of geriatrics.

It has been suggested that 9 or 10 clinical faculty and the same number of basic science faculty are necessary for an integrated clinical care, teaching, and research program in geriatrics and gerontology for medical students and house staff. At present, the NIA, the National Institute of Mental Health, and the Veterans Administration are training between 100 and 140 new individuals a year. Preliminary survey results indicate that approximately 70 percent are continuing in full-time academic positions in geriatrics and gerontology. However, the Nation needs to train more geriatric faculty to meet the needs of the next 15 years. The academic community, along with the private sector, needs to share responsibility with the Federal, State, and local governments to reach these goals.

How can we train sufficient faculty for educational and training programs in gerontology and geriatrics? The DHHS report recommends increased training and education in this crucial area by strengthening existing programs and by creating innovative new programs. The NIA has responded with several new approaches. The first of these initiatives is the Geriatric Leadership Academic Award. This is a 3-year grant to support a senior faculty member at a health science school who will actively assume a leadership role in stimulating and guiding the development of programs for research and training in geriatrics and gerontology. This initiative is specifically targeted at those institutions which currently do not have extensive programs in aging.

As another approach to stimulate geriatric training, the NIA has announced the Complementary Training Award for Research on Aging. This award supports additional fellowship positions specifically targeted toward aging as part of already funded Public Health Service research training grants in a variety of disciplines. Other NIA grant mechanisms which support geriatric and gerontologic training include the individual and institutional National Research Service Award and Physician Scientist Award (for fellows and beginning faculty), the Clinical Investigator Award and the Academic Award (for new faculty members), the Research Career Development Award (for mid-level faculty members with research grant support), the Senior Fellowship Award (for support of senior faculty who wish to extend their research into the field of geriatrics), and the Behavioral Geriatrics Award (for scientists interested in multidisciplinary training).

In addition to the NIA, other Federal agencies such as the National Institute of Mental Health, the Administration on Aging, the Health Resources and Services Administration, and the Veterans Administration support other aspects of education and training in these areas. The DHHS Committee is continuing to work together to foster these efforts. The recently enacted Public Law 99-158 reauthorizing the NIH, directs the Secretary of HHS to report to Congress on personnel needs for health care of older people; this committee is undertaking the preparation of this report.

It is timely for the private sector to contribute to this important endeavor. Foundations such as the Hartford Foundation, the Kaiser Family Foundation, and the Brookdale Foundation either have funded or plan to fund a limited number of fellowship positions. It is also particularly pleasing to see the foresight of a corporation like The Travelers Insurance Companies which, in collaboration with the National Council on Aging, has supported research training of medical students under their Geriatric Medical Student Fellowship Program. Most recently, this enlightened company has funded a chair in geriatrics at the University of Connecticut. We hope that other foundations and corporations will participate in supporting educational and training programs in gerontology and geriatrics so that sufficient numbers of individuals will be trained to provide for the future needs of our aging population.

I will be pleased to answer any questions which the Committee may have. Thank you.

Response to questions from Senator Charles E. Grassley to Dr. T. Franklin Williams regarding geriatric education and training:

Question: It has been alleged that better training for physicians in the special medical needs of the elderly can make medical services for the elderly, in the aggregate, more effective and economical. Would you accept the assertion that we can eventually save money by investing in geriatric training for physicians, and, if so, can you give me some examples of how this could happen?

Response: Lack of knowledge of normal aging and the unique health needs of older people has been shown to lead to inappropriate and excessive use of acute and long-term care services, especially use of hospitals and nursing homes. For example, one of the first reported studies of a geriatric evaluation and placement service, in 1973 (one in which I was involved), showed that half the patients on waiting lists for nursing home admission (in this study) had not had an adequate medical work-up from a geriatric perspective (that is, they had potentially remediable problems), and that through such a service the majority of older persons who were already on waiting lists for admission to nursing homes were enabled to go instead to less intensive institutional levels of care or to continue to live at home. In more recent studies, geriatric in-patient units and consultative teams in hospitals as well as ambulatory geriatric services have been shown to achieve earlier discharge, better functional status, and less overall use of hospital days, with frail and complexly ill older patients, than was achieved by conventional services. In these specialized geriatric services the involvement of professionals properly trained in geriatrics has been essential to their success in improving the quality of the outcomes for patients and families as well as in reducing the use of the more costly services. Such studies support the view that better geriatric training for all physicians could avoid some of these delays in hospital discharge and avoid the need for nursing home admissions in the first place; as well as the view that we benefit by having a smaller group of geriatric specialists who can contribute to the quality and cost-effectiveness of care for older patients with especially complex problems.

Question: Can you tell us briefly, what's different about the elderly which requires physicians to have special training in geriatrics?

Response: Special characterisitcs of older people which require special training for appropriate care -- that is, special training in geriatrics -- include:

1) A different spectrum of presenting symptoms or complaints from younger people. For example, falls are the single most common event or complaint leading to hospitalization in older people -- a very rare event in younger people. Thus practitioners caring for older patients must learn about causes, risk factors,

and likely consequences of falls and how to prevent and treat them in older people. Other examples could be cited.

2) Chronic problems producing sustained morbidity and loss of function and independence, rather than simple acute problems, are the major challenges in older persons, calling for new and different learning. For example, by far the most common causes of disability in persons over the age of 85 are arthritis, dementia, strokes, peripheral vascular disease, and hip fractures; in contrast, the major causes of mortality in middle and later years, such as coronary artery disease and cancer, produce very little of the chronic disability found in very old people. Continued emphasis in education and research on the latter conditions is of course important; but geriatric training and research must also include the common causes of chronic disability.

3) Older people typically have multiple complex health and social problems, rather than a single, relatively simple problem, at any one time. Geriatric competence requries the ability to address these multiple problems simultaneously.

4) In the face of such chronic disabling problems there is the special importance of achieving even small gains in function through treatment and rehabilitation, rather than being disappointed that one cannot achieve a simple, complete cure, as the pysician commonly expects to accomplish in the treatment of younger patients.. For example, if an older patient with a stroke and partial paralysis can be helped to learn to transfer independently from bed to chair (or commode or wheel chair), he/she can be virtually independent in most daily activities even though still considerably disabled. Thus a different attitude must be learned as a part of geriatrics.

5) The special crisis, faced eventually by 20-40% of older persons and their families, is the need to consider some arrangement for major long term care, at home or in an institution, because of declining physical and/or mental function often complicated by loss of social supports. Such crises call for special skills on the part of the physician-geriatrician, with the collaboration of specially trained nurses, social workers, and often other consultants, to work out care plans that are most appropriate for the patient and most in line with his/her and the family's preferences. This type of situation rarely arises in younger patients; it is where special geriatric training is most important.

Overall, all physicians should learn more about all five aspects described here. In addition, we need a group of geriatric specialists who can teach the others (and other professionals) as well as provide specialty consultative help in the crisis situations such as those just referred to and as described in the answer to the previous question.

Question: Some analysts argue that physicians who have a large proportion of older people among their clientele should know a good deal about non-medical aspects of older people's situation. In your opinion, how important are the patient's social and cultural environment and a knowledge of available societal resources in the training of geriatric physicians?

Response: As indicated in the preceding answer, social problems are very commonly, indeed almost always, present along with medical problems in many of the critical situations which arise for older patients and their families. All physicians caring for older patients must understand these problems and their interrelations with the medical problems and must be able to work successfully with nurses and social workers skilled in helping address these problems. The success of the outcomes, in terms of function, satisfaction, and costs, will depend upon the successful addressing of these interacting medical and social problems. Physicians specializing in geriatrics will be able to teach other physicians and, in teamwork with social workers, be best able to deal wth particularly complex situations.

Senator MATSUNAGA [presiding]. Thank you very much, Dr. Williams and Mr. Hatch. I do not believe there are any questions at this point. If there are, we will submit them in writing to you for the record.

Thank you very much.

Dr. WILLIAMS. Thank you.

Mr. HATCH. Thank you, Senator.

Senator MATSUNAGA [presiding]. Our next panel of witnesses will consist of Dr. Samuel O. Thier and Dr. John Beck.

Dr. Thier is president of the institute of medicine, and Dr. Beck, director of the multicampus division of geriatric medicine, UCLA School of Medicine.

We would be happy to hear from you, Dr. Thier.

STATEMENT OF DR. SAMUEL O. THIER, PRESIDENT, INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES; AND DR. JOHN BECK, PROFESSOR OF MEDICINE, AND DIRECTOR, MULTICAMPUS DIVISION OF GERIATRIC MEDICINE, UCLA SCHOOL OF MEDICINE

Dr. THIER. Senator Matsunaga, thank you. I too will try and shorten my testimony and ask that the whole testimony that I have submitted be included in the record.

Senator MATSUNAGA. It will be so ordered.

Dr. THIER. Barbara Tuchman defined as folly pursuing a policy contrary to one's own self interest, even when the self interest is obvious and a feasible alternative course exists.

I am not sure we have committed folly in our health policy toward the aging, but we certainly are at risk of doing so. There is not any issue as obviously capable of overwhelming our health care system as the needs of our aging population. And yet there is not other major issue in health that has elicited so feeble a response.

The good news about aging is that we have underestimated the number of people who will live to healthy and productive advanced age. The bad news is that we have also underestimated the number of frail elderly we will have to care for in the next few decades. The worst news is that we have not heeded warnings and advice about how to prepare for the aging of our population—and that approaches folly.

Elderly are not simply patients who are older. Research has emphasized physiologic differences of cardiovascular function, neuromuscular abilities, and drug metabolism that make them a special population for the physician. Their proper care requires that the physician have special training, and that is what you are considering here.

The Institute of Medicine reported nearly a decade ago that if we were to provide proper care for our elderly, we would have to improve the education of providers of care about the issues of aging. The Institute emphasized the need to conduct research into the spectrum of issues involved in aging.

The report called for increases in the quality and quantity of training in geriatric medicine because the number of trainees was wholly insufficient to meet the projected needs.

Two of the impediments to training leaders in geriatric medicine were identified as an absence of clearly defined career tracks and lack of direct support for training faculty.

The Institute recommended four steps for overcoming these impediments: one, increasing the research base of geriatrics; two, developing academicians to serve as models to attract more young medical professionals into geriatrics; three, establishing postresidency training for those young professionals, and four, requiring accreditation and certification in geriatrics.

The Institute's investigation did not indicate a need for developing a new and separate specialty, but rather, found that proper education within the primary care specialties, such as internal medicine and family practice, would meet the Nation's requirements.

In the decade since that report, and largely because of the efforts of the National Institute on Aging and other institutes of the NIH, the research base of geriatrics has increased substantially. There is now great promise for the future of that research.

The private sector's response includes the boards of internal medicine and family practice announcing that they will examine and certify diplomats for special competence in geriatrics. Thus half of the recommendations of the Institute of Medicine for training leaders in geriatric medicine have been undertaken.

But the critical matters of developing geriatric academicians, and of establishing an adequate number of postresidency training programs have not been resolved.

Because the issue has become more, not less, urgent, the Institute of Medicine recently convened a meeting of representatives from government, academia, foundations, and certifying organizations to examine fresh strategies for dealing with the enormous shortfall in the number of academic leaders in geriatrics.

Several observations of that meeting are germane to Senate bill 2489.

First, all agreed that we had fallen far short of our needs for leaders in academic geriatrics. Second, there was a sense that our needs were both short term and long term, and that programs such as that introduced by the Hartford Foundation, to permit midcareer changes of faculty into geriatrics, provided one model for a short-term solution, but involved a very small number of faculty.

The long run, it appears, could employ some variation on the most productive model used in other academic medical fields—that is, the development of centers of excellence with a critical mass to which young persons are drawn for training and from which they go forward to begin their own centers of excellence. There is a need to provide time for faculty within such centers to establish firmly their own academic credentials, and to be protected from service in order to teach.

The private sector has reorganized itself in terms of certification and has attempted short-range solutions stimulated by philanthropic foundations. The problem of our aging population, a population covered by Medicare, represents a national commitment of enormous and growing magnitude.

Senate bill 2489, to improve the training of physicians in geriatrics, is consistent with the advice the Institute of Medicine provid-

ed nearly a decade ago. It represents a proper step, although a modest one, away from a path to folly. One hopes that it represents a step toward an overall plan of dealing with the health of our aging population.

Thank you.

Senator MATSUNAGA. Thank you very much, Dr. Thier.

[The prepared statement of Dr. Thier and responses to questions submitted by Senator Grassley follow:]

TESTIMONY

BY

SAMUEL O. THIER

PRESIDENT

INSTITUTE OF MEDICINE

NATIONAL ACADEMY OF SCIENCES

TO THE

SUBCOMMITTEE ON AGING

COMMITTEE ON LABOR AND HUMAN RESOURCES

U.S. SENATE

JUNE 26, 1986

SENATOR GRASSLEY, I AM DR. SAMUEL O. THIER, PRESIDENT OF THE INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMY OF SCIENCES. I AM PLEASED TO HAVE THIS OPPORTUNITY TO TESTIFY ABOUT SENATE BILL 2489 TO IMPROVE THE TRAINING OF PHYSICIANS IN GERIATRICS.

BARBARA TUCHMAN DEFINED FOLLY AS PURSUING A POLICY CONTRARY TO ONE'S OWN SELF INTEREST EVEN WHEN THE SELF INTEREST IS OBVIOUS AND A FEASIBLE ALTERNATIVE COURSE EXISTS. I AM NOT SURE THAT WE HAVE COMMITTED FOLLY IN OUR HEALTH POLICY TOWARD THE AGING BUT WE CERTAINLY ARE AT RISK OF DOING SO. THERE IS NO ISSUE SO OBVIOUSLY

CAPABLE OF OVERWHELMING OUR HEALTH CARE SYSTEM AS THE NEEDS OF OUR AGING POPULATION. AND YET THERE IS NO OTHER MAJOR ISSUE IN HEALTH THAT HAS ELICITED SO FEEBLE A RESPONSE.

THE GOOD NEWS ABOUT AGING IS THAT WE HAVE UNDERESTIMATED THE NUMBER OF PEOPLE WHO WILL LIVE TO HEALTHY PRODUCTIVE ADVANCED AGE. THE BAD NEWS IS THAT WE ALSO HAVE UNDERESTIMATED THE NUMBER OF FRAIL ELDERLY WE WILL HAVE TO CARE FOR IN THE NEXT FEW DECADES. THE WORST NEWS IS THAT WE HAVE NOT HEEDED WARNINGS AND ADVICE ABOUT HOW TO

PREPARE FOR THE AGING OF OUR POPULATION...AND THAT APPROACHES FOLLY.

THE HEALTH OF THE ELDERLY POSES A PARTICULAR CHALLENGE TO MEDICAL SCIENCE. THEY ARE NOT SIMPLY PATIENTS WHO ARE OLDER. RESEARCH HAS EMPHASIZED PHYSIOLOGICAL DIFFERENCES OF CARDIOVASCULAR FUNCTION, NEUROMUSCULAR ABILITIES, AND DRUG METABOLISM THAT MAKE THE ELDERLY A SPECIAL POPULATION FOR THE PHYSICIAN. THEIR PROPER CARE, HOWEVER, REQUIRES THAT THE PHYSICIAN HAVE SPECIAL TRAINING. AND THAT IS WHAT YOU ARE CONSIDERING HERE.

THE INSTITUTE OF MEDICINE REPORTED NEARLY A DECADE AGO THAT IF WE WERE TO

PROVIDE PROPER CARE FOR OUR ELDERLY AND MAINTAIN THEIR MAXIMUM USEFUL FUNCTION, WE WOULD HAVE TO IMPROVE THE EDUCATION OF PROVIDERS OF CARE ABOUT THE ISSUES OF AGING. THE INSTITUTE EMPHASIZED THE NEED TO CONDUCT RESEARCH INTO THE BIOLOGY OF AGING, INTO THE DISEASES OF THE AGED, AND INTO THE ORGANIZATION AND DELIVERY OF CARE TO THE ELDERLY IF WE HOPED TO PROMOTE HEALTH AND PREVENT DISEASE AMONG OUR AGING PEOPLE. THE INSTITUTE REPORT CALLED FOR INCREASES IN THE QUALITY AND QUANTITY OF TRAINING IN GERIATRIC MEDICINE BECAUSE THE NUMBER OF TRAINEES WAS WHOLLY INSUFFICIENT TO MEET THE PROJECTED NEEDS. TWO OF THE MAIN

IMPEDIMENTS TO TRAINING LEADERS IN GERIATRIC MEDICINE WERE IDENTIFIED AS AN ABSENCE OF CLEARLY DEFINED CAREER TRACKS AND A LACK OF DIRECT SUPPORT FOR TRAINING FACULTY. THE INSTITUTE OF MEDICINE RECOMMENDATIONS FOR OVERCOMING THESE IMPEDIMENTS INCLUDED 1) INCREASING THE RESEARCH BASE OF GERIATRICS, 2) DEVELOPING ACADEMICIANS TO SERVE AS MODELS TO ATTRACT MORE YOUNG MEDICAL PROFESSIONALS INTO GERIATRICS, 3) ESTABLISHING POST-RESIDENCY TRAINING PROGRAMS FOR THOSE YOUNG PROFESSIONALS, AND 4) REQUIRING ACCREDITATION AND CERTIFICATION IN GERIATRICS. THE INSTITUTE'S INVESTIGATION DID NOT INDICATE A NEED FOR

DEVELOPING A NEW AND SEPARATE SPECIALTY OF GERIATRICS BUT RATHER FOUND THAT PROPER EDUCATION WITHIN THE PRIMARY CARE SPECIALTIES, SUCH AS INTERNAL MEDICINE AND FAMILY PRACTICE, WOULD MEET THE NATION'S REQUIREMENTS.

IN THE DECADE SINCE THAT REPORT, AND LARGELY BECAUSE OF THE EFFORTS OF THE NATIONAL INSTITUTE ON AGING AND OTHER INSTITUTES OF THE NATIONAL INSTITUTES OF HEALTH, THE RESEARCH BASE OF GERIATRICS HAS INCREASED SUBSTANTIALLY. NEW KNOWLEDGE NOW BEGINS TO SHOW GREAT PROMISE FOR FUTURE DEVELOPMENT ACROSS THE ENTIRE SPECTRUM OF RESEARCH OPPORTUNITIES, FROM THE BASIC

BIOLOGY OF AGING TO THE STUDY OF ALZHEIMER'S DISEASE AND FURTHER TO RIGOROUS EVALUATION OF HEALTH CARE SERVICES FOR THE ELDERLY. THE PRIVATE SECTOR'S RESPONSE INCLUDES THE BOARDS OF INTERNAL MEDICINE AND FAMILY PRACTICE ANNOUNCING THAT THEY WILL EXAMINE AND CERTIFY DIPLOMATES FOR SPECIAL COMPETENCE IN GERIATRICS. THUS HALF OF THE STEPS RECOMMENDED BY THE INSTITUTE OF MEDICINE FOR TRAINING LEADERS IN GERIATRIC MEDICINE HAVE BEEN UNDERTAKEN. BUT THE CRITICAL MATTERS OF DEVELOPING GERIATRIC ACADEMICIANS AND OF ESTABLISHING AN ADEQUATE NUMBER OF POST- RESIDENCY TRAINING PROGRAMS HAVE NOT BEEN RESOLVED.

BECAUSE THE ISSUE HAS BECOME MORE, NOT LESS, URGENT, THE INSTITUTE OF MEDICINE RECENTLY CONVENED A MEETING OF REPRESENTATIVES FROM GOVERNMENT, ACADEME, FOUNDATIONS, AND CERTIFYING ORGANIZATIONS TO EXAMINE FRESH STRATEGIES FOR DEALING WITH THE ENORMOUS SHORTFALL IN THE NUMBER OF ACADEMIC LEADERS FOR GERIATRICS. THE PROCEEDINGS OF THAT MEETING ARE PRESENTLY BEING COMPILED AND WILL SERVE AS A BASIS FOR ONGOING EFFORTS AT THE INSTITUTE TO ENHANCE TRAINING IN CARE OF THE ELDERLY.

ALTHOUGH THE PROCEEDINGS OF THAT CONFERENCE MUST UNDERGO REVIEW BY THE NATIONAL RESEARCH COUNCIL BEFORE FINAL

RECOMMENDATIONS CAN BE MADE, I CAN COMMENT ON SEVERAL OBSERVATIONS AT THAT MEETING GERMANE TO THE BILL YOU ARE CONSIDERING TODAY. FIRST, ALL AGREED THAT WE HAD FALLEN FAR SHORT OF OUR NEEDS FOR LEADERS IN ACADEMIC GERIATRICS. SECOND, THERE WAS A SENSE THAT OUR NEEDS WERE BOTH SHORT-TERM AND LONG-TERM, AND THAT PROGRAMS SUCH AS THAT INTRODUCED BY THE HARTFORD FOUNDATION, TO PERMIT MID-CAREER CHANGES OF FACULTY INTO GERIATRICS, PROVIDED ONE MODEL FOR SOLUTION OF A SHORT-TERM PROBLEM. FOR THE LONG RUN IT APPEARS THAT WE COULD EMPLOY SOME VARIATION ON THE MOST PRODUCTIVE MODEL USED IN OTHER ACADEMIC MEDICAL FIELDS: THAT IS

THE DEVELOPMENT OF CENTERS WITH A CRITICAL MASS OF EXCELLENCE TO WHICH YOUNG PERSONS ARE DRAWN FOR TRAINING AND FROM WHICH THEY GO FORWARD TO BEGIN THEIR OWN CENTERS OF EXCELLENCE. THERE IS A NEED FOR PROVIDING TIME FOR FACULTY WITHIN SUCH CENTERS TO ESTABLISH FIRMLY THEIR OWN ACADEMIC CREDENTIALS AND TO BE PROTECTED FROM SERVICE COMMITMENTS IN ORDER TO TEACH.

IT IS MY SENSE THAT THE PRIVATE SECTOR HAS REORGANIZED ITSELF IN TERMS OF CERTIFICATION, AND HAS ATTEMPTED SHORT-RANGE SOLUTIONS STIMULATED BY PHILANTHROPIC FOUNDATIONS. THE PROBLEM OF OUR AGING POPULATION, A POPULATION COVERED BY MEDICARE

REPRESENTS A NATIONAL COMMITMENT OF ENORMOUS AND GROWING MAGNITUDE. THE BILL BEFORE YOU TODAY TO IMPROVE THE TRAINING OF PHYSICIANS IN GERIATRICS IS CONSISTENT WITH THE ADVICE THE INSTITUTE OF MEDICINE PROVIDED NEARLY A DECADE AGO. IT REPRESENTS A PROPER STEP ALTHOUGH A MODEST ONE, AWAY FROM A PATH TO FOLLY. ONE HOPES THAT IT REPRESENTS A STEP TOWARD AN OVERALL PLAN OF DEALING WITH THE HEALTH OF OUR AGING POPULATION.

THANK YOU.

INSTITUTE OF MEDICINE
NATIONAL ACADEMY OF SCIENCES
2101 CONSTITUTION AVENUE WASHINGTON, D.C. 20418

SAMUEL O. THIER
PRESIDENT

July 14, 1986

The Honorable
Charles E. Grassley
United States Senator
Committee on Labor and Human
Resources
Washington, D.C 20510

Dear Senator Grassley:

Under separate cover I am responding to the questions you have directed to me on geriatric education and forwarding these to the Subcommittee on Aging. Enclosed is a copy for your information. I appreciate the opportunity to comment further and provide additional information for the record of the hearing on "Geriatric and Gerontological Education and Training".

With best wishes,

Sincerely,

Samuel O. Thier, M.D.

Answers from Dr. Samuel O. Thier to Questions from
Senator Charles E. Grassley Regarding
Geriatric Education and Training

Q. It has been suggested that older people are different from a medical point of view. Perhaps we should establish that there is a body of knowledge about these differences that can be taught. Is there any dispute about that.

A. The current consensus is that there is a distinct body of knowledge dealing with syndromes occurring in the older patient that are not seen in other groups. In my testimony I mentioned representative areas in which altered function and response to treatment makes older individuals a group requiring special attention. Medical personnel, from the medical student on up, are not being required to learn this information (it is often an elective subject) despite the increasing percentage of older patients that they treat.

Research to further understand and subsequently to treat these syndromes is also sorely needed. This research would obviously add to the body of geriatric knowledge which needs to be taught.

Q. You have argued that it would be unwise to create a geriatric specialty in medicine. I am certainly in no position to question your judgment on that question. But I am curious, is there any universal agreement?

A. There is almost certainly not universal agreement on whether a separate geriatric specialty should be created in medicine. However, both family practice physician groups and internal medicine professional groups (who together provide the bulk of care to older persons) have agreed that geriatrics is too important to be a separate specialty, but should be an added competence for physicians. The American Board of Medical Specialties, which is charged with approving new specialties, has agreed to this concept.

In the 1978 Institute of Medicine report, "Aging and Medical Education," the committee chaired by Paul B. Beeson, M.D., clearly recommended that "a formal practice specialty in geriatrics not be established, but that gerontology and geriatrics be recognized as academic disciplines within the relevant medical specialties."

Q. Mr. Hatch, in his statement, noted several indicators of increasing interest in geriatric education. Does this activity indicate that the medical training system will respond to the changing needs of our society by providing sufficient faculty to train our primary care physicians and that we will have, in due course, the number of adequately trained teaching geriatricians that we need? If not, why not, and what further steps need to be taken?

A. In order to provide sufficient faculty to train our primary care physicians, the system must be primed with sufficient funds and

established "centers of excellence" to both train the needed faculty geriatricians and then give them quality opportunities to train fellows in the field. Difficulties in knowing the present number of geriatricians rests on ambiguity in defining a geriatrician with respect to type of practice, individuals vs. full-time equivalents, etc. Estimates, however, range from 250-300 full-time physician faculty to 1618 full-time equivalent geriatricians including clinicians, teachers, and researchers. Estimates indicate that by the year 1990, 8,000-10,000 clinicians and 900-1,500 faculty will be needed to provide quality care to older Americans. Currently, there are fewer than 100 geriatricians being produced each year. Hence, the current medical training system is not sufficiently responding to these needs.

The 1978 IOM report stated two main impediments in the medical training system to producing faculty leaders in geriatric medicine. They were (1) an absence of a clearly defined faculty career track in geriatrics and (2) lack of direct support for training this faculty. The report suggested: (1) increasing the research base of geriatrics; (2) developing academicians to serve as models; (3) establishing post residency training programs; and (4) requiring accreditation and certification.

As of 1986, the research base of geriatrics has increased substantially, and standards for accreditation and certification have been adopted by relevant medical specialty boards. Developing faculty in geriatrics and establishing fellowship training programs still remain urgent needs.

A recent meeting at the IOM to address these problems proposed the following:

- In the short term, funded programs are needed to train medical career faculty in geriatric medicine who could then serve as a training source for other faculty and fellows. These faculty need protected time to return to their home institutions and begin viable programs, as well as research support to carry on research in geriatrics. This would give an immediate increase in the number of available trainers.

- In the long term, funded programs are needed to develop "centers of excellence" with a critical mass for training fellows who could then train our primary care geriatricians.

These steps should raise both the quality and quantity of leaders and practitioners in the field of geriatric medicine.

Senator MATSUNAGA. We will now hear from Dr. Beck.

Dr. BECK. Mr. Chairman, I too will attempt to shorten my remarks and would hope that my submitted testimony is included in the record.

Senator MATSUNAGA. It will be so ordered.

Dr. BECK. What I would like to do, sir, is to review very briefly for you the previous manpower projections which have been made in this Nation, largely in Los Angeles, and to then review for you data which have been collected largely by my colleagues and myself at UCLA on what has been the national response to date, further elaborating on Dr. Thier's remarks.

If you would turn to table 1, page 19, you will note in tables 1, 2, and 3 the projections which were made by a group at Rand and UCLA in 1980, which suggested that there was at that time a need for 1,600 faculty members in geriatric medicine, 450 in geropsychiatry. Because we perceived that the private sector required substantial numbers of geriatricians who would not be academicians, and because we perceived that very complex problems in the elderly would require fully-trained geriatricians for their management, we suggested that by 1990, there was a total need for somewhere between 7,000 and 10,300—(FTE)—persons trained in geriatric medicine.

In table 3, you will note a response that we made to the National Institute on Aging at their request on geriatric research manpower needs, which again was made in 1981. And finally, in table 4, you will note the minimum faculty number targets, which were made by the committee which Dr. Frank Williams referred to and which shows, by the year 2000, that our medical schools would require 2,600 faculty persons trained in geriatric medicine and geropsychiatry.

Now, where have we come in terms of these various predictions? I would like to address that first in terms of undergraduate medicine, then in terms of residency training, then in terms of fellowship training in geriatric medicine and geropsychiatry, and finally in terms of continuing medical education.

If you would refer to table 5, it looks at the changes in undergraduate medical education, and I would remind you that in 1976, some years previous to the first survey of 1983-84, there were only a handful of programs that offered undergraduate medical education. You will also note that there has been a substantial improvement in the number of course offerings to undergraduate medical students at both the preclinical and clinical years. However, if one surveys medical students, as we were able to do and as the AAMC was able to do, we found in 1984-85 that only 2.3 percent of all graduating medical students had had a meaningful experience in geriatric medicine. The AAMC survey revealed 3.2 percent in the year previously—figures that are remarkably close together.

Turning next to residency training, in 1979-80—and I would refer you to table 6—there were 28 units in the country that were offering some form of residency training in medicine or family practice. We do not have data on psychiatry. In 1983-84, on the basis of data collected by a colleague at State University of New York, Buffalo, Dr. Calkins, that number had increased to 40, in which approximately 43 percent of the trainees in internal medicine and family

practice were having 1 month's experience in geriatric medicine. This is in sharp contrast to the 442 residency programs in internal medicine and the 380 residency programs in family practice, and I think again emphasizes what Dr. Thier has said, that we have fallen far short of the target.

Turning next to fellowship training—and I would refer you to table 7—these are really our future faculty and future leaders of activities in the private sector. Prior to 1970, there were two fellowship programs in this nation. And if you look at table 7, you can see that there has been a progressive increase so that in 1985-86, there were 48 programs with 166 fellowship positions open for training at an advanced level.

I also wish to emphasize that in 1984–85, that is, June 30, 1985, there were only 51 graduates of fellowship programs in medicine and family practice and 34 in geropsychiatry. Approximately half of these individuals went to academe and half to the private sector. And as one of the previous witnesses has mentioned, we have identified just under 400 fully trained geriatric physicians and geropsychiatrists in this country to date and are at present surveying them in terms of what they are actually doing.

Finally addressing continuing medical education—in table 8—you see that there is once more a change. There is almost a doubling in the course offerings. But I want to point out to you that in our 1984–85 study of continuing medical education, which was sponsored by the VA central office, we estimated—and this was a very generous estimate—that no more than 8,000 out of 450,000 practicing physicians in this Nation had had a full day's continuing medical education in geriatric medicine or geropsychiatry.

I will not mention research or practice, since this has been alluded to, but would like to turn to the need for revision of our manpower or personnel needs from our perspective. These are targets for the year 2000.

Our initial projections which were made in 1980—which we examined—in table 1, need to be totally revised because the population projections for this country have increased since these initial analyses. Second, the population projections for persons over the age of 85 have increased very substantially.

Third, there is an unexpected, and major demand for formally trained geriatricians and geropsychiatrists in HMO's, community hospitals and clinics, and as leaders of the long-term care institutional system.

And finally, our own personal conviction at UCLA, based on experience, that there will be a need for specially-trained geriatric consultants who will bear the responsibilities for the ongoing care of very complex and frail elderly persons, hoping to maintain them in the community.

I believe the GMENAC manpower personnel projections requires revision for similar reasons.

In terms of these assumptions, we believe that we must target in this Nation for somewhere near 20,000 full-time-equivalents by the year 2000, a very substantial revision upward. We believe that this could be achieved by educating and training 7,000 geriatricians which would be both for academe—the 2,600 referred to in the De-

partment of Health and Human Services Study, which is the most recent one—plus the need in the private sector.

We think there would be a need for approximately 13,000 full-time-equivalent internists and family physicians who are well-trained in geriatric medicine but would not be considered to be geriatricians.

If each of this latter group devoted 50 percent of their time, then one would actually have to expose 26,000 family physicians and internists moving through our training system over the next one and a half decades to a very substantial experience to geriatric medicine and geropsychiatry.

We believe that the key to meeting the challenges which I have described above is the development of a nucleus of faculty that can sustain and advance the teaching and research effort with its positive effect on clinical practice for this Nation. We do not generally at the moment have such a nucleus, nor will one automatically emerge simply because of the demographic shifts in this Nation. It is also our firm conviction that if we are to increase our faculty strength from the roughly 2½ per medical school as of 1983 to the somewhere between 10 and 20 which was mentioned by Dr. Williams, that a major new effort has to be embarked on.

Supporting the development of geriatrics in the way that I have described means a commitment or redirection of monetary resources to sustain the sizable effort needed. The funding in the past has been transient. The uncertainty continues to plague long-term development plans in academic geriatric medicine.

We have a framework in place. There is a beginning major commitment of funds, but one that must be much increased so that we might have a positive impact on the care of our Nation's elderly and the cost of care.

I believe we are at an historic moment in the field of geriatrics because of the climate of interest and the readiness to participate in the clinical and research communities. There is a need and opportunity to make a national impact through geriatric training to facilitate adequate mainstreaming of geriatric expertise into general training and to promote research.

And if you will permit, as I close, I would like to quote Shakespeare: There is a tide in the affairs of men which, taken at the flood, leads on to fortune; omitted, all the voyage of their life is bound in shallows and miseries.

Thank you for the opportunity of testifying.

[The prepared statement of Dr. Beck and responses to questions submitted by Senator Grassley follow:]

TESTIMONY TO THE SUB-COMMITTEE

ON AGING

COMMITTEE ON LABOR AND HUMAN RESOURCES

U. S. SENATE

June 26, 1986

JOHN C. BECK, M.D.

PROFESSOR OF MEDICINE, UNIVERSITY

OF CALIFORNIA, LOS ANGELES

DIRECTOR

UCLA MULTICAMPUS DIVISION OF GERIATRIC MEDICINE,

DIRECTOR

UCLA ACADEMIC GERIATRIC RESOURCE CENTER

Mr. Chairman (Charles E. Grassley) and Members of the Committee, I am a Professor of Medicine at the University of California, Los Angeles; the Director of UCLA's Multicampus Division of Geriatric Medicine and the Director of the UCLA Academic Geriatric Resource Center. Thank you for the opportunity to speak to you about the need for physician health professionals to aid in dealing with improving the quality of health care of elderly Americans.

I. INTRODUCTION

In this country, we face the challenge of an increasing number of elderly persons, which is also the success story of the 20th century. The demographic facts are widely known -- we are living longer, we are growing older as a nation and we are witnessing the beginning of a tremendous outlay of national resources for the acute and long term care of the elderly.

In 1978 the Institute of Medicine described a specific body of knowledge regarding aging, emphasizing the skills and attitudes that are relevant to the education of physicians and the practice of medicine in a landmark report. There is increasing agreement that older persons are special from a health care standpoint in the following ways:

- o Shorter life expectancy;
- o Diminished reserve, less resilience, easily disrupted homeostasis;

- Stresses abound, depression common;
- Multiple chronic diseases;
- Many causes for malnutrition;
- Many causes for functional disability;
- Many sources of pain and discomfort; and
- Special pharmacological considerations.

These factors combine to produce extraordinary complexity in the medical care and treatment of many elderly persons. As the number of older persons continues to grow, so, too, will the number of physicians needed who have special expertise in the multiple, interactive problems of aging.

II. MANPOWER (PERSONNEL NEEDS AND PROJECTIONS)

In 1980 a Rand/UCLA group made estimates of the number of academic and practicing geriatricians in full time equivalents (FTEs) which would be needed in this nation. These data are displayed in Tables 1, 2 and in Figure 1 (pages 19 to 21). In summary, it was noted that the USA would require between 7,000 and 10,300 geriatricians by the year 1990 with the best intermediate figure being about 8,000. These estimates were based on the assumption that geriatricians would provide improved care to persons over the age of 75 in both an academic consultant and primary care role with the delegation of a moderate amount of responsibility to nurse practitioners, physicians assistants and social workers. These estimates were also a function of the then-

predicted number of elderly persons, their average rate of utilization of health care providers and on the productivity of health care providers.

These physician manpower needs in geriatrics were updated at the request of the National Institute on Aging in 1981 with a particular emphasis on Geriatric Research Manpower Needs. These data are summarized in Table 3 (page 22).

The most recent faculty member estimates were made in a Report on Education and Training in Geriatrics and Gerontology by the Department of Health and Human Services in 1984. The pertinent information is summarized in Table 4 (page 23).

III. THE PRESENT NATIONAL RESPONSE

The "geriatric imperative" as it has been called by Somers and others presents a three-fold challenge:

- to educate,
- to perform research; and
- to improve practice

Using data collected largely at UCLA, let me review where we are as a nation in meeting some of these challenges. Following this, I will update our projections of the number of geriatric faculty and practitioners needed and, finally, I wish to emphasize the

critical role to be played by geriatric faculty and fellows if we are to improve the quality of life and care of our aging population.

Undergraduate Medical Education

In 1976, two medical schools had required undergraduate courses in gerontology or geriatrics, and only 15 had separate educational programs of any kind. Four years later, 76 schools reported 133 programs (lecture course, clerkship) at the undergraduate level, of which 84 were in the clinical years. In 1983-84, 169 clinical programs were reported, doubling the 1979-80 figure. Additionally, 103 of 125 medical schools reported some type of geriatric program in the clinical years. Table 5 (page 24) summarizes the growth in undergraduate programs. The growth in programs has been accompanied by the development of educational materials, including course outlines, teaching modules and textbooks.

While the gains at all levels of medical education are impressive, the absolute amount of instruction received by medical students is generally acknowledged to be inadequate. Virtually all studies of the status of formal geriatric education include the caution that there are few required or selective courses and that the number of students enrolling in elective offerings is very small accounting for approximately 2.3% of all third and fourth year students in 1984. This figure corresponds closely

with the results of the 1983 Association of American Medical Colleges (AAMC) Graduation Questionnaire, which reported 3.2% of students taking a clinical elective experience in geriatrics in either the preclinical or clinical years.

Residency Training

Similar increases have taken place at the residency level. Calkins at S.U.N.Y.-Buffalo, for example, reports a doubling of mandatory house staff rotations offered by established academic units in geriatric medicine in the 1983-84 academic year from the level observed in 1979-80. In 1979-80, there were approximately 28 such units in the country, of which 21% offered mandatory (to half or more of the residents) geriatric rotations. In 1983-84, the number of such units had grown to 40 and the percent with mandatory rotations had increased to 43%. This is in contrast to the 442 residency programs in Internal Medicine and the 380 programs in family practice. While it is true that some programs provide geriatric training in the absence of an established geriatric unit, the number which do so is minimal and the quality of rotations suspect. Current residency training data are presented in Table 6 (page 25).

Fellowship Training

Geriatric medicine fellowship training has more than doubled in the last five years as shown in Table 7 (page 26). In 1984-85, there were 45 geriatric medicine fellowship programs recruiting fellows; up from 24 programs in 1980-81 and up from just two prior to 1970.

In these 45 programs seeking fellows in the 1984-85 academic year, there were a total of 136 positions available, of which 126 were filled. Of the 126 participating fellows, 76 were in their first year, 46 in their second year, and four had elected to do a third fellowship year devoted to research. Fifty-one fellows completed their training in June, 1985.

The data for the 1985-86 academic year show an expansion to 48 programs and a total number of 176 fellowship positions. For 1986-87 and beyond, we estimate that up to sixty programs may be in place.

Funding is coming from university medical centers (27 of 45 programs), the Veterans Administration (19 of 45 programs), and the private sector (10 of 45 programs). Two programs received state funding.

At the fellowship level, the 51 physicians completing a geriatric program in June of 1985 are in decided contrast to the 178 in pulmonary, 193 in gastroenterology and 249 in cardiology. By our estimate, in fact, no more than 400 physicians have ever had fellowship training in geriatric medicine or geropsychiatry. We believe that fewer than half of this number has gone into faculty positions, the remainder being engaged in non-academic activities, primarily practice-oriented. This leaves us with a significant shortfall in the number of highly trained geriatricians needed to fill faculty positions and to provide clinical care.

Continuing Medical Education

Geriatrics-related continuing medical education has seen rapid growth in the last few years as seen in Table 8 (page 27). Beginning in January of 1975, 36 programs devoted solely to geriatrics were held over a period of 30 months. In 1984-85, 85 such programs were held over a 24-month period. A recently-completed UCLA study of the 85 programs held in 1984 and 1985 demonstrates that while a few highly-rated subject areas such as pharmacology, ethical/legal issues, preventive medicine, dementia, osteoporosis, depression, hypertension, incontinence and decreased mental function are covered in at least one out of five courses, many subjects -- rated as highly by experts -- are covered infrequently or not at all, for example congestive heart failure, anemia, iatrogenic problems, coping with death and dying,

electrolyte and fluid disorders, diverticulitis, hypotension and hypochondriasis (as the somaticization of depression). Topics along the lines of functional assessment, clinical approach to the elderly patient, iatrogenesis and long term care (continuum of care) are generally absent. These are so fundamental to care of the elderly, that they should be a feature of virtually every course. Unfortunately, it has been the experience of many geriatric faculty that these are topics most physicians feel are either not important or that they can already handle. The evidence, however, is on the side of less than an adequate quality of care for older people, and this is certainly a part of it.

In supporting the need for more continuing medical education, Wessler has pointed out that while the number of elderly people is growing, the vast majority of practitioners, especially those whose formal training ended before 1975, have never been exposed to organized geriatric education in medical school, residency or fellowship training. In our study of geriatrics-related CME, we projected that for 1984 and 1985 combined, no more than 8,000 -- and very probably fewer -- physicians attended at least one day of CME devoted solely to geriatrics. This is out of a total population of over 450,000 practicing physicians.

In summary, recent studies have shown that for all types of undergraduate and graduate medical education and training (including continuing medical education), geriatric content is

almost totally lacking and/or in need of redirection. In terms of the present legislative initiative, formal geriatric instruction at the residency level is even less frequent than it is at the undergraduate level. Fellowship training, while experiencing a doubling between 1980 and 1984, still produced only 51 graduates for the entire nation in June of 1985. The number of academic geriatricians emerging from fellowship programs continues to fall far short of the projected need and will continue to do so unless a substantial redirection of resources takes place. In a similar vein, continuing medical education activities directed towards geriatrics has doubled in recent years but our observation suggests that critically important subjects are presented infrequently or not at all.

Research

The scope of research by geriatricians should be as broad as possible. In a burgeoning field such as geriatrics, there is a need for research of three types: 1) basic (or biomedical) research; 2) clinical research; and 3) health services research. The Institute of Medicine has identified a number of areas in which major breakthroughs in basic research are indeed possible. These would include the areas of immunology, mechanisms of aging, basic studies in physiology, neurology and neuropathology, endocrinology, and the like. More extensive discussion can be found in comprehensive reviews of research opportunities

published by the NIA.

The repertoire of potential clinical work to be done in geriatric research is almost boundless. There is a need for careful clinical trials of a variety of therapies, including drug therapies and the use of new kinds of milieu interventions, such as for incontinence. In the area of health services research, better work is needed to develop new techniques for appropriately assessing the variety of geriatric problems and the development of new taxonomies. We need to look at new configurations of care, exploring such models of care as the geriatric assessment unit. Geriatricians are sorely needed to develop more effective methods of giving care within the nursing home, to experiment with new record-keeping systems and more effective use of teamwork. Better linkages between the nursing home and other parts of the long-term care spectrum and between the long term care spectrum and the acute medical care system should also be explored.

Again, as with educational programs, our current response is very limited, and the lessons of other newly arrived fields in academic medicine (e.g., family practice) should be appreciated. Simply put, the tasks of developing clinical and teaching programs extract a great price from the first generation of academic leaders. Unless active efforts are undertaken to prevent it, research and other scholarly activity is relegated to a lower priority in the press to mount new programs. In the case

of geriatrics, which cannot draw upon the wisdom of extant practitioners, we are working under severe handicaps. Not only are we concerned with the nurturing of academic geriatricians, we are also sensitive to the great need for new and better information about the clinical problems faced by the growing number of elderly in this country. An academic geriatrician cannot make sufficient progress in research on these complex problems with, at most, only a limited amount of time available for this purpose.

In addition to doctoral-level (Ph.D.) researchers, physician researchers trained in the techniques of biomedical, clinical or health services research are necessary to provide a working bridge between the laboratory and the geriatric clinic. We estimate that, at a minimum, an average of two such academic geriatrician research faculty for each of our 127 medical schools are needed today to make progress in geriatrics possible. We recognize that these 254 physicians may not be equally distributed across all institutions, but the total number will likely fall in this range. Mechanisms must be developed to recruit, train, and reward such persons if we are to find new answers to geriatric problems and to re-examine the answers currently promulgated.

It is especially disappointing that not only are our fellowship programs producing so few graduates, very few of these have spent a fellowship year (usually the third year) devoted to developing

research skills. Throughout the 16 internal medicine subspecialty areas with fellowship programs, approximately one-third of all fellows remain for a third year of research. In geriatrics, the figure is less than 14%, the lowest of any internal medicine subspecialty area. The shortfall in the number of geriatric fellows is compounded by the shortfall in their experience with conducting research.

Practice

The shortcomings in the medical care generally received by older persons is becoming well known. UCLA faculty and colleagues have shown that physicians spend statistically significantly less time with their older patients. In two separate studies, we have also recently shown that in the typical medical encounter, many important porcedures (e.g., pap smears) are often omitted from the examinations of older people and that diagnoses of dementia, depression, osteoporosis and incontinence are often missed.

We cannot expect these patterns of practice to change until we have established more medical school curriculum time devoted to geriatrics, more postgraduate (residency and CME) training and a larger number of high quality fellowship programs.

Manpower/Personnel Needs Revised

The projections of geriatric manpower needs made by the Rand/UCLA group in 1980 needs substantial revision for the following reasons:

1. Population projections have increased since these initial analyses;
2. Population projections for persons over the age of 85 have increased substantially;
3. There is an unexpected demand for formally trained geriatricians in HMOs, community hospitals and clinics, and as leaders in the long term care system (both institutional and noninstitutional); and
4. My own personal conviction, and that of my colleagues, based on our experience, that specially-trained geriatric consultants will need to bear the responsibility for ongoing care in a proportion of the frail elderly because of the complexity of the problems encountered.

In a similar vein, review of the Graduate Medical Education National Advisory Committee (GMENAC) adjusted-needs-based model and their manpower projections suggests that a similar reanalysis needs to be engaged in.

In terms of our own observations, we believe that we must target for about 20,000 FTEs, a substantial upward revision from our previous projections. We believe that this could be achieved by

the education and training of 7,000 geriatricians and about 13,000 (FTE) internists and family physicians who were well trained in geriatric medicine but who could not be considered to be geriatricians. If each of this latter group devotes 50% of its time to practice with the elderly we are really considering the development of a mechanism for training about 26,000 internists and family physicians to develop above average expertise in dealing with older persons. I cite this since residency training in these specialties must obviously be totally redirected as must the resources to support them.

The Need for Geriatric Faculty and Fellows

We believe that the key to meeting the challenges I have described above is the development of a nucleus of faculty that can sustain and advance the teaching and research effort with its positive resulting effect on clinical practice. We do not generally, at the moment, have such a nucleus nor will one automatically emerge simply because of the geriatric imperative. It must be supported and encouraged.

The highly visible presence of a core faculty of geriatric physicians is the key to affecting the practice patterns, attitudes, and skills of medical undergraduates and young physicians in caring for the elderly. This faculty must have a presence in the academic medical center, in long-term care facilities, and in ambulatory clinics. It should be able to

synthesize the expertise of others involved in the care of the elderly and present it in a manner relevant to the medical students and house officers who care for older people.

To influence students successfully in the appropriate care for the elderly, we must once more recognize the key influence of the medical housestaff on students. It is essential that these post-M.D. physicians recognize the importance of geriatrics faculty teaching efforts and that they acquire the attitudes, knowledge, and skills to pass this on to their students. It is also axiomatic that resident physicians will not become advocates of geriatrics until the geriatrics faculty helps them in the management of their patients in both the inpatient and ambulatory services. In this vein, it is essential that geriatrics be taught in a factual manner supported by as much data as exists and as many key references as possible.

The curriculum must emphasize the care of the frail and dependent elderly whose chronic illnesses or physical or mental disability require the help of others in their daily activities. Clinical judgment about care of the elderly is a critical ingredient, and while difficult to impart, requires the transmittal of some basic principles to clinicians in training. The usual clinical strategies almost invariably deserve alteration in very old patients.

Emerging clinicians should be taught about a number of specific problems that affect the elderly whose assessment and management usually lies with the general physician. These problems include the dementias, acute confusional states, instability and falls, pressure sores, and urinary incontinence.

The role of physicians in aiding elderly patients and their families in arriving at long-term-care decisions must be recognized. Young clinicians must be prepared to assess the functional needs of patients and to aid in the provision of the resources to fill these needs. In so doing, young clinicians must recognize and understand the role of other disciplines critical to the care of the elderly and implementing them in an effective manner. Finally, emerging physicians must become familiar with the practical but ever-changing workings of the long-term-care system that is evolving in the United States. We are not recommending that the physician replace the social worker, but are convinced that the physician supplies critical complementary skills to the social worker in arriving at appropriate decisions about Medicaid, Medicare, intermediate care facilities, home health care agencies, skilled nursing facilities, and many other aspects of the support system that has developed. Absence of this input is evident to anyone who manages older patients in emergency rooms.

Geriatric faculty. In 1983 the number of geriatric faculty was estimated nationally to be an average of 2.5 FTE per medical school. They are derived from two sources: 1) established

mid-career and senior faculty who have turned their teaching and research focus to geriatrics from another area of medicine; and 2) graduates of fellowship programs, who now constitute a small pool of junior faculty in departments of medicine, family practice and psychiatry.

We believe that to be effective, an institution must have a core of 10 to 20 faculty members, both junior and senior, fully committed to geriatrics. In order to be a balanced effort, ten to twelve positions would be regular, tenure-track faculty with both teaching and research responsibilities. Another six would be adjunct faculty at affiliated hospitals, and the remaining two would be fully committed to research.

The major source of faculty for geriatrics is likely to be fellowship programs, and we must attract individuals to them in sufficient numbers and train these individuals adequately if we are to meet the geriatric challenges before us.

In the decade in which we are beginning to experience the predicted oversupply of physicians, the trained geriatrician finds himself or herself a much sought-after commodity. Fellows graduating from our program at UCLA receive dozens of job offers, and I am sure that this phenomenon is observed in other programs as well. With the need for geriatricians to fill positions on university faculties, HMOs and in long term care institutions and

community hospitals and clinics, the situation will continue for years to come. As a result, we can expect to see more and higher quality applicants for geriatric fellowship training.

We are also beginning to see more professional recognition for the trained geriatrician. Beginning in 1988, the American Board of Internal Medicine will sponsor an examination for "Added Qualification" in Geriatric Medicine. Similarly, the American Board of Family Practice will offer special recognition. Increased recognition and prestige is thus accompanying the need for trained geriatricians.

Supporting the development of geriatrics in the way I have described means a commitment of monetary resources to sustain the sizable effort needed. Funding has been transient, and uncertainty continues to plague long term development plans. We have the framework in place, and a major commitment of funds will have a pronounced positive impact on the care of our nation's elderly and the cost of such care. I believe we are at a historic moment in the field of geriatrics because of the climate of interest and readiness to participate in the clinical and research communities. There is the need and opportunity to make a national impact through geriatric training to facilitate adequate mainstreaming of geriatric expertise into general training and to promote research.

TABLE 1

ESTIMATES OF NEED FOR GERIATRICIANS
IN ACADEMIC MEDICINE

UPPER LIMIT

MEDICAL SCHOOLS	124 x 3.0	372
TEACHING HOSPITALS		
INTERNAL MEDICINE ALONE	328 x 2.0	656
FAMILY PRACTICE ALONE	230 x 1.5	345
BOTH	128 x 2.5	320
TOTAL		1693
CORRECTION FOR UNIVERSITY HOSPS.		90
NET		1603

LOWER LIMIT

MEDICAL SCHOOLS	124 x 3.0	372
TEACHING HOSPITALS		517
TOTAL		889

(BASED ON THE FUTURE NEED FOR GERIATRICS MANPOWER IN THE UNITED STATES, KANE, R.L., SOLOMON, D.H., BECK, J.C., KEELER, E, AND KANE, R.A., NEJM, JUNE, 1980)

TABLE 2

ESTIMATES OF MANPOWER NEEDS FOR GERIATRIC CARE

Recipient-Based Data

Number of geriatricians needed is a function of:

1. **Number of persons in pertinent age groups (65+ or 75+) at selected dates (1977, 1990, 2010, 2030)**
2. **Average annual rate of utilization of services of health care providers (visits per year per person)**
3. **Productivity of health care providers (visits per year per provider FTE)**
4. **Factor for improved care**

$$\text{Number needed (in FTE)} = \frac{1 \times 2}{3} \times 4$$

(Based on The Future Need for Geriatrics Manpower in the United States, Kane, R.L., Solomon, D.H., Beck, J.C., Keeler, E, and Kane, R.A., NEJM, June, 1980)

FIGURE 1

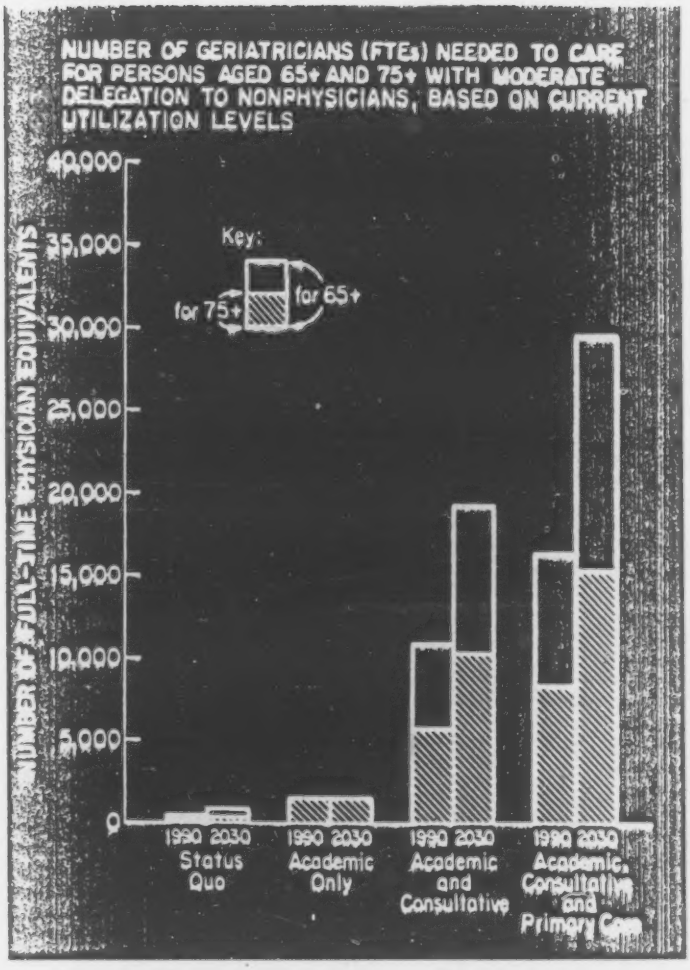
NUMBER OF GERIATRICIANS (FTEs) NEEDED TO CARE FOR PERSONS AGED 65+ AND 75+ WITH MODERATE DELEGATION TO NONPHYSICIANS, BASED ON CURRENT UTILIZATION LEVELS
NUMBER OF FULL-TIME PHYSICIAN EQUIVALENTS
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
Key:
for 75+
for 65+
1990 2030
Status Quo
1990 2030
Academic Only
1990 2030
Academic and Consultative
1990 2030
Academic, Consultative and Primary Care

TABLE 3

ESTIMATED GERIATRIC RESEARCH MANPOWER NEEDS

ACADEMIC GERIATRICIANS	900-1600 FTE
ACADEMIC GEROPSYCHIATRISTS	450 FTE
TOTAL	1350-2050 FTE
RESEARCH GERIATRICTIANS FTE @ 25%	325-512 FTE
+1 DOCTORAL-LEVEL RESEARCHER PER GERIATRIC FACULTY	1350-2050 FTE
GERIATRIC PHYSICIAN SCIENTISTS	250 FTE

(SOURCE: PHYSICIAN MANPOWER NEEDS IN GERIATRICS: PROJECTIONS AND RECOMMENDATIONS, KANE, R.L., BECK, J.C., SOLOMON, D.H., MARCH 1981)

TABLE 4

MINIMUM FACULTY MEMBER TARGETS

FACULTY MEMBERS SHOULD BE PERPARED FOR TEACHING AND RESEARCH IN GERIATRICS AND GERONTOLOGY. THE FOLLOWING MINIMUM TARGETS FOR THE YEARS 1990 AND 2000, FOR WELL-PREPARED FACULTY MEMBERS WHOSE PRIMARY COMMITMENTS ARE IN GERIATRICS AND GERONTOLOGY SHOULD BE CONSIDERED:

	1990	2000
MEDICAL SCHOOLS-PHYSICIANS	600	1300
MEDICAL SCHOOLS-OTHER FACULTY	600	1300
NURSING SCHOOLS	750	1500
DENTAL SCHOOLS	80	120
SOCIAL WORK SCHOOLS	300	1000
OPTOMETRY SCHOOLS	80	125
PHARMACY SCHOOLS	150	300
CLINICAL PSYCHOLOGY PROGRAMS	150	450

(SOURCE: REPORT ON EDUCATION AND TRAINING IN GERIATRICS AND GERONTOLOGY, ADMINISTRATIVE DOCUMENT, NATIONAL INSTITUTE ON AGING, DEPT. OF HEALTH AND HUMAN SERVICES, FEBRUARY, 1984)

TABLE 5

NUMBER AND CHANGE IN NUMBER OF PROGRAMS:
1979-80 vs. 1983-84
(current returns compared to same
medical schools and departments
in 1979-80)

Sponsoring Depts:	Internal Medicine (n=68)	Family Practice (n=37)*	Psychiatry (n=37)	Total (n=142)
Number of clinical programs in 1983-84:	91	31	47	169
Number of clinical programs in 1979-80:	50	19	15	84

* 13 of the 142 programs were co-sponsored but are counted only once (mostly as Internal Medicine); thus, the lower number of Family Practice programs (31) than sponsoring departments (37).

(SOURCE: EDUCATION IN THE CLINICAL YEARS: DELUSION OR REALITY, VIVELL, S, ROBBINS, A.S., SOLOMON, D.H., AND BECK, J.C. BULL. N.Y. ACAD. MED., JULY-AUGUST, 1985)

TABLE 6

Residency Training in Geriatrics

25

Year	Source	Data
77-78	d	LCGME identified 20 of 753 Internal Medicine and Family Practice (no breakdown) programs that required rotations in geriatrics
79-80	a	35 of 92 medical schools and institutions reported 44 graduate programs, one-third of which were required
4/84	c	see table below

TABLE I. BLOCK TYPE ROTATION IN GERIATRICS
(30 Units Reporting)*

*refers to 30 of 37 established academic units in geriatric medicine identified as of April, 1984

A. Internal medicine
Total units offering block rotation: 25(83%)

Mandatory	*18(60%)*
Percent of residents participating	Number of units
100%	8
90%	1
50-75%	3
20-30%	5
10%	1
Elective	*8(27%)*
(Currently electing)	
4 residents	2
2 residents	3
1 resident	1
0	1
Both	*4(13%)*

B. Family medicine (30 units reporting)
Total units offering block rotation: 8(30%)

Mandatory	*4(13%)*
Percent of residents participating	
100%	3
4%	1
Elective	*4(13%)*
Number of residents participating	
1 4	
3	1
2	2

C. Internal medicine, family medicine or both
Total units offering mandatory block rotation: 13(43%)

Sources

a = UCLA (Resource Guide, J. Med. Ed. or Bull. N.Y. Acad. Med.)
b = UCLA in preparation
c = Calkins (Bull. N.Y. Acad. Med.)
d = IOM Aging and Medical Education Report
e = NASIMM (National Survey of Internal Medicine Manpower)
f = Pennington (N.Y. State J. Med.)

TABLE /

GROWTH IN FELLOWSHIP PROGRAMS

YEAR	TOTAL			INTERNAL MED.		PSYCHIATRY	
	No. PROGRAMS	No. POSITIONS	% FILLED	No. PROGRAMS	No. POSITIONS (GRADUATES)	No. PROGRAMS	No. POSITIONS (GRADUATES)
1980-81	36			25	67 (28)	11	20 (12)
1981-82	36		85	25	75	12	
1982-83	37	97		24		11	19
1984-85			93	45	136 (51)	13	40 (34)
1985-86				48	166		

TABLE 8

GERIATRIC MEDICINE C M E

(AMA CREDIT AND AT LEAST ONE DAYS DURATION)

YEAR	SOURCE	
1975-77	(PENNINGTON N.Y. STATE J. MED)	36
1984	(UCLA)	41
1985	(UCLA)	45

UNIVERSITY OF CALIFORNIA, LOS ANGELES UCLA

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DEPARTMENT OF MEDICINE
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July 22, 1986

Honorable Charles E. Grassley
United States Senator
Chairman Subcommittee on Aging,
Committee on Labor and Human Resources
Washington, D.C., 20510

Dear Chuck:

My apologies for not having responded to your letter of June 27, 1986 but it only reached my office on July 10th. At the time I was away from Los Angeles advising the government of Alberta, Canada on its future development of services for older people, including its personnel/manpower problems.

I shall address the questions which accompanied your letter in the following paragraphs.

1. Mr. Hatch, in his statement, noted several indicators of increasing interest in geriatric education. Does this activity indicate that the medical training system will respond to the changing needs of our society's population by providing sufficient faculty to train our primary care physicians and that we will have in due course the numbers of adequately trained teaching geriatricians that we need?

There is no question that there is a response by the medical training system but as one looks at it in perspective (as my testimony points out) this response has been slow in coming and is falling far short of the manpower/personnel needs for this nation. To dramatize this, my testimony revealed that only a very small proportion of the over 16,000 graduates of U.S. medical schools received a meaningful experience in the care of the elderly. (The number ranges from 2.3 percent to 3.2 percent on the basis of the national data available.) At the level of core training of internists and family physicians the situation is equally desperate. Of the 442 residency programs in internal medicine and the 380 programs in family practice there would appear to be on the basis of 1985 data, no more than 40 experiences exist of which 43 percent were mandatory. At the fellowship training level the last data available reveals 51 physicians exiting programs in geriatrics in contrast to, for example, 178 in pulmonary disease, 193 in gastroenterology and 249 in cardiology. In fact, no more than 400 physicians have ever had fellowship training in geriatric medicine and geropsychiatry in this nation and the demand for these personnel is nearing a national crisis. At the continuing medical educational level we believe that for 1984 and 1985 combined no more than 8,000 of the approximately 450,000 practicing physicians in this country has substantial CME experiences. By substantial we mean that physicians attended at least one day of CME. Our estimate of 8,000 we consider to be a generous one.

2. If not, why not and what further steps need to be taken?

The reasons for less than an ideal response has multiple causes but perhaps the most major of these is the absence, nationally, of adequate numbers of fully qualified faculty capable of taking up the education and training responsbilities. My testimony also pointed out that in the upward revision of our manpower needs we now estimate that 20,000 Future Time Equivalents (FTE's) would be needed by the year 2000. Of this group 7,000 would be geriatricians and about 13,000 (FTE) internists and family physicians who are well trained in geriatric medicine, but not considered to be geriatricians. If each of this latter group devotes half of their time to practice with the elderly we are really facing the development of educational and training programs for about 26,000 internists and family physicians to develop above average expertise in dealing with older persons. The faculty requirement to bring this about in the core residency training programs I believe to be approaching a crisis state in this nation.

The steps which need to be taken are once more multiple, but perhaps the most critical is the development of adequate numbers of Centers in this nation who could begin to produce faculty in large numbers to be distributed to the sites where they are needed. This is clearly an early and first step and when these faculty are produced and in place the resources necessary to support them in their educational and training activities directed at both the undergraduate, the core training in internal medicine and family practice, and in continuing medical education would take place. The reasons for inadequate numbers of sites capable of developing new faculty being present in this nation is clearly a resource problem, although there are other influences which bear upon it. There are inadequate, stable funding mechanisms which can permit the development of adequate numbers of sites capable of developing new faculty.

3. You have been involved in training geriatric teachers for a long time. How do you support your faculty now?

We have been involved in the development of training faculty for the nation's medical schools since 1978-79. Our own faculty at the moment have been supported from a variety of relatively stable as well as highly unstable sources as have our fellowships stipends. The faculty support has come through the Veterans Administration, the UCLA School of Medicine, National Institute of Aging special awards to faculty, both senior and junior, and from private foundation support. The sources as you can see range from reasonably stable to sources which are of short duration and highly unstable.

How many fellows are you training now?

With the support of the Veterans Administration, private foundations, and UCLA Medical Center funds, we have a steady state of between twelve and sixteen fellows in training. The training program is of two and three years duration respectively. In addition we have had from one to three mid-career faculty who in a period of a year have redirected their activities into geriatric medicine. Their funding has come from foundation sources and from their own institutional sites. Our sources of fellowship stipends are again highly unstable. Foundations have not been willing to stay in this activity for longer than three to five years; the constraints on advanced trainees in internal medicine through the traditional funding sources are a constant threat; and finally even the stability of the Veterans Administration funding has been in question on several occasions since we started our programs.

4. And can you tell us what use you would make of the type of support which would be provided by the program contemplated by this bill?

As I have implied elsewhere in response to your questions the support of faculty and fellowship stipends is highly unstable. In a period where there are constraints, and actual outbacks in the support of the present number of medical school faculty, it is exceedingly difficult for deans of schools of medicine to maintain their present support of geriatric faculty, much less increase the number. Our training capacities with the number of faculty we have at hand in the UCLA family (which includes our VA Medical Center sites) is at maximum capacity. Were we to lose faculty, through the present instability in funding some of them, we would have to cut back on our training capacity. The legislation proposed would facilitate increasing our training capacities at all levels of the medical education continuum and particularly at the core training level in internal medicine and family practice, the fellowship level and in continuing medical education.

I am delighted with the opportunity to be able to respond to your questions and would be happy to elaborate further on them.

Yours sincerely,

JBeck

John C. Beck, M.D.
Professor of Medicine
Director, Multicampus Division
of Geriatric Medicine

Senator MATSUNAGA. Thank you very much, Dr. Beck and Dr. Thier.

Do you believe that the private sector cannot do what the Government is now proposing to do?

Dr. THIER. I think not. I think the activities that have been attempted by the private sector, which I laud, are activities such as those of the Hartford Foundation, which funded a very small number of people at midcareer.

What is needed is a mechanism of support which provides the opportunity for individuals who are coming out of their training to have protected time to develop a research and academic career which would put them in the mainstream. They must be able to work along with their colleagues and to develop a relationship that makes academic geriatrics a key part of an ongoing broader academic program.

I do not think that the foundations, at least the ones that have been involved thus far, can deal with the numbers of individuals that we are talking about. They can play a very important role in filling in gaps where there are aspects of programs which could be facilitated by private sources of support. At our recent IOM meeting, we had the foundations—Hartford, Dana and others—involved so that they would have a sense of where they might get the greatest leverage for their support. But the problem is a much, much broader one than that, and I fear that telling ourselves that it can be taken care of without Government participation is going to create the same mistake we have made for the last decade.

Senator MATSUNAGA. Dr. Beck?

Dr. BECK. I would like to add to Dr. Thier's remarks. I have had part of my career in the foundation world, and there really only have been three foundations in this nation which have shown substantial interest in the problem we are discussing today. One was Henry J. Kaiser Family Foundation in Palo Alto which initially, in terms of stimulating the development of geriatric medicine, funded a very limited number of programs with the clearcut, typical foundation strategy of saying; We want to do this to point out to the whole nation that this needs to be done, and funds have to come from elsewhere, since we are not committing our funds forever.

Subsequently to that, Hartford Foundation, as you have heard, has developed a modest program in support of midcareer training, and more recently the Brookdale Foundation out of New York has developed again a very modest program.

The numbers of facilities produced through these mechanisms are far short of what is needed to meet the national need.

Senator MATSUNAGA. Considering the fact that there is a definitely growing population of the aged, and as I understand it today in America, 200 every week celebrate their 100th birthday—I was amazed to learn about that—and realizing that this population will continue to increase—in 1900 it was just 2 percent; today it is 11 percent—and in the beginning of the next century, it will be 22 percent—I would think that the medical schools themselves would require those who are learning to become doctors to take courses in geriatrics and gerontology.

Are the medical schools doing anything in this regard?

Dr. BECK. The medical schools, sir, are doing all that they can. They are in a period—and Dr. Thier can respond as well—of major fiscal constraint, as faces many other areas within our society. Their major limitation in a response is the absence of trained faculty to teach geriatric medicine and geropsychiatry. We cannot expect our medical schools to begin to educate our medical students and house staff until we have got bodies around who can do it. And the nation has not got them.

Dr. THIER. I think that is the real message about the earlier comments related to the presence of increasing amounts of geriatrics in the curriculum. In essence, what you have is a geriatric curriculum, taught by talented amateurs. And that will never achieve the kind of sticking power and kind of attention that is required until it has the kind of faculty that can also be part of a collegial group and hold their own on the basis of the quality of what they produce, in scholarly terms as well as teaching terms.

Dr. BECK. I support that completely.

Senator MATSUNAGA. As the years go by, more and more I begin to believe in what you say.

Dr. THIER. We hope you will have a long time to do that.

Senator MATSUNAGA. Well, thank you very much.

Dr. THIER. Thank you.

Senator MATSUNAGA. Our next panel of witnesses consists of Dr. Gregory Pawlson, representing the American Geriatric Society, and Associate Chairman, Department of Health Care Sciences, George Washington University and Ms. Ina Guzman, who is a consultant with a major interest in private support for geriatric education.

I will be happy to hear from you.

Dr. Pawlson, please proceed

STATEMENT OF DR. L. GREGORY PAWLSON, REPRESENTING AMERICAN GERIATRIC SOCIETY, AND ASSOCIATE CHAIRMAN, DEPARTMENT OF HEALTH CARE SCIENCES, GEORGE WASHINGTON UNIVERSITY; AND INA GUZMAN, CONSULTANT WITH MAJOR INTEREST IN PRIVATE SUPPORT FOR GERIATRIC EDUCATION

Dr. PAWLSON. Thank you very much. I will also try to highlight some of the areas in my written report.

First of all, we feel that the care of the frail elderly can be improved in terms of function and perhaps even survival with little or no increase, or in some cases an actual reduction, in the overall costs of health care through the application of some of the principles of geriatric medicine. I think that is a very important factor in terms of trying to produce training in geriatric medicine.

There have been studies in the hospital environment, both in the acute and rehabilitative phase of hospitalization, and in the outpatient area, both in office practice and in home care, which support my contention.

These are not high technology, costly interventions that we are talking about, but rather, if enough teachers were available in geriatric medicine, they are things that most physicians in training could learn.

Second, we feel that putting a limited amount of funding—and we understand the limitations of its availability—into the creation of faculty in geriatric medicine, would be the most efficacious investment of Federal dollars and could have a major impact on training of individuals throughout the country.

By doing this, I think we would create a cascade effect, so that by funding a few individuals at the faculty level, you could supply some direct teaching of residents and students. In addition faculty oversee fellowship programs which in turn produce more faculty for the academic centers, as well as physicians who will go out into practice and be the consultants in hospitals and outpatient environments across the country. Thus you can have a very significant effect on training in many different areas throughout the country with a relatively small investment.

Finally, there are a couple of things that I would like to point out in terms of why, and your previous question was a very timely one, in terms of why this isn't going to happen on its own.

I think there are a number of things about geriatric medicine that are going to prevent its' developing in as timely a manner as we would hope it would.

First of all, geriatrics has emerged in the wrong time and in the wrong place. It has emerged during a period of rather painful but necessary restraints on health care expenditures. Tuition dollars, research dollars, and clinical income dollars in academic medical centers are very different in terms of their rate of increase than they were in 1960.

Second, geriatric medicine is a very time-intensive kind of practice. There are no big ticket procedures that we can do to earn $5,000 in an hour and thereby be able to subsidize our educational activities at other times.

Third, geriatric education includes the use of sites such as nursing homes and outpatient practice, which have no provision for reimbursing trainees as does the hospital. The hospital is still a major source of funding for both faculty and especially for fellowship programs in areas other than geriatric medicine. A recent report by a group looking at funding of fellowship programs in internal medicine showed that geriatrics had one of the smallest proportions of funding from hospital sources as compared to other fellowship training areas.

I think that despite the fact that we are trying to produce shorter stays and better care for the elderly through geriatric medicine, we are still going to be losers in the eyes of many hospitals since we take care of more complex patients who are going to have a longer length of stay regardless of how well we try to provide their care.

I would submit that hospital directors might be seen as rather poor financial managers if they were to shift resources to programs like geriatric medicine which not only cannot provide enough money to keep themselves going, but also bring in frail elderly patients, which hospital directors may see as revenue losers under the prospective payment system.

I would like to close with a clinical vignette, if I might. This is a patient that I just happened to see this morning—being a local, I made my usual rounds this morning before coming here this after-

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noon. I asked this patient for her permission to use her name and case in talking with you.

Her name is Gladys Lack, and she is an 87-year-old lady who spent her life counseling disadvantaged youth. She was diagnosed as having breast cancer about 8 years ago, and 1 year ago suffered the onset of very severe acute back pain, which was diagnosed as a metastatic lesion of her breast cancer. She took to her bed; she became very depressed; she stopped eating and was really looking for possible hospice care when we first saw her.

I went back and looked through the records for evidence that this was metastatic cancer—recognizing that many elderly people have vertebral collapse of the spinal column from osteoporosis or bone-softening. Indeed, as it turned out, her problem with eating was due to an esophageal stricture which was benign and could be corrected; and she did not have metastatic breast cancer but a vertebral compression fracture from osteoporosis. She is no longer depressed and has started seeing some of her former clients again.

I think that the case illustrates the kind of thing that we are talking about. It is not high-tech. It did not take a $10,000 intervention, but it produced a patient who is much better off at a relatively low cost to the health care system.

Thank you.

Senator MATSUNAGA. Thank you, Doctor.

[The prepared statement of Dr. Pawlson and responses to questions submitted by Senator Grassley follow:]

STATEMENT

OF THE

AMERICAN GERIATRICS SOCIETY

BEFORE THE

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

SUBCOMMITTEE ON AGING

JUNE 25,1986

MR CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE

I am L. Gregory Pawlson M.D.,M.P.H. an internist and geriatrician and Head of the Center for Aging Studies and Services at George Washington University. I am here today representing the American Geriatrics Society in which I serve on the Executive Board and as Chairman of the Public Policy Committee. The American Geriatrics Society has approximately 5,000 members, largely physicians, from a variety of disciplines including internal medicine, family practice and psychiatry. Our primary goal is to improve the care of the elderly through research, education and innovation in clinical practice. Our membership represents the full spectrum of geriatric medicine from private practioners providing primary care to the elderly, through researchers involved in basic science and clinical investigation of the diseases that afflict so many of our senior citizens.

Building on the testimony you have already heard concerning the need for more physicians trained in geriatric medicine, I would like to focus on three additional points.

1. A growing number of studies indicate that geriatric assessment and management can result in better patient care at the same or even reduced costs of care.

2. The provision of funding at the level of faculty and fellowship education has a multiplier effect that will significantly expand the impact of the investment of federal funds.

3. Because of current funding and reimbursement patterns, geriatric education is unlikely to expand without specific intervention by the Congress.

Geriatric assessment and management are key elements in the care of elderly persons with multiple diseases and psychosocial problems. While the procedures involved are somewhat time intensive, they do not require expensive new technologies. Investigations of the effectiveness of geriatric assessment have shown promising results in both the hospital and outpatient setting. Studies of the acute phase of hospitalization of frail elderly persons in Great Britain, as well as studies done by our group at George Washington, indicate that care by physicians with geriatric training results in a shorter length of stay with the same or better outcomes. In the rehabilitative phase of hospital care, a study done at a Veterans Administration affiliated with UCLA, demonstrated improved patient outcomes including functional status, morale and survival with fewer hospital readmissions, nursing home days and lower overall costs when care was provided in the geriatric assessment unit.

In the outpatient setting, preliminary results from a project done at the University of North Carolina indicate that geriatric assessment and management of frail elderly persons in the outpatient

setting can result in enhanced function, reduced use of nursing homes, fewer hospital admissions and lower over all expenditure for health care. Other data from the Home Medical Service at Boston University suggest that home care provided by geriatricians can reduce the number of hospitalization required by the frail elderly. These studies and others which in the interests of time I will not review, indicate the possibility that through education and training of physicians, in all fields that relate to the care of the elderly, we can improve the care of the elderly without adding significantly to the already high cost of health care. Such training will not occur without a significant increase in the number of physicians available to teach geriatrics.

I would like to turn now to a consideration of how we might expand training and education in geriatric medicine with in the most cost-effective manner. First it is clear that the field of geriatric medicine will evolve, not as a seperate speciality as it has in Great Britain, but as a area of special focus within existing specialities, specifically internal medicine, family practice and possibly psychiatry. Indeed, the American Boards of Internal Medicine and of Family Practice have stated their intent to give certifying exams in geriatric medicine by the spring of 1988. By remaining within the mainstream of these and other specialities, geriatric medicine can have an major impact on the training of most of the physicians who care for the vast majority of elderly persons. This positioning of geriatric medicine within Internal Medicine, Family Practice and other specialties requires a broad approach to the funding of geriatric training.

As you have heard the major factor limiting training in geriatric medicine is the lack of a sufficient number of qualified faculty to act as teachers and role-models. This lack of a suffient number of faculty

is due, in turn, to the small number of training programs which provide faculty in geriatric medicine and increasingly limited support for new medical school faculty. Providing relativly limited funding for increasing the number of faculty with expertise in geriatrics can a have a significant impact on the training of a large number of physicians, especially if such funding is tied to the expansion of fellowship training programs. The first step, in what could be called the multiplier effect, is that a relatively modest number of faculty can provide the expertise and direction for the training of geriatric fellows. Geriatric fellows are physicians who have finished their basic residency training in their speciality field, such as internal medicine or family practice, and who desire advanced training in geriatric medicine within that speciality field. When their training is compleated most fellows assume major teaching roles. However even while in training, fellows play a significant role in the education of residents, interns and medical students. New faculty and fellows also provide a very crucial source of fresh ideas and manpower for the research which may some day remove the diseases that cause so much suffering for our elders. This cascade or multiplier effect of a small number of new faculty is the reason why investing in a program that is aimed at the faculty level may prove to be the most effective means of expanding geriatric education and, more importantly, improving the care of the elderly.

My final point is directed at the question which is perhaps most important to members of Congress: Why do we need federal dollars and legislation to increase education in geriatric medicine? I would like to offer the following reasons in support of our need for your intervention:

1. Geriatrics has had the misfortune to emerge during a period of increasing limits on income in academic medical centers. These limits have been noted in all three of the major sources of income for academic medical centers-tuition, research and patient care. Medical school tuition has reached levels in some institutions, such as my own, of over $20,000 per year. At this level, further tuition increases to fund new programs is almost unthinkable. Funding for research, after a period of rapid increase in the 60's is declining in real dollar terms. Finally, necessary, but still painful efforts to control health care expenditures, have reduced the availability of clinical income that might have been used to cross-subsidize the development of geriatric medicine.

2. Geriatric medicine is a very time intensive endevour with no highly reimbursed "high tech" procedures. Further, efforts to limit Medicare expenditures have had a disproportionate effect on the practice of geriatric medicine. While other physicians may have shifted some of the rising costs of practice during the Medicare freeze by raising fees for non-Medicare patients such shifting is impossible when your practice is, by design, all elderly patients. In addition, since most patients cared for by academic geriatricians are already burdened by poverty or very high medical care costs, it is usual to accept Medicare assignment. Taken together these factors insure that income from clinical practice is not sufficient to subsidize education.

3. Despite the enhanced efficiency and effectiveness noted in the studies which I cited earlier, the care of frail elderly persons, which is the basis of clinical geriatrics, is seen by hospitals as a revenue loser under the current system of Medicare reimbursement. Hospital revenues account for a substantial proportion of the funding for faculty and fellowship salaries in areas other than geriatric medicine.

Data from the annual survey of Internal Medicine manpower indicates that geriatric medicine fellowships derive a substantially smaller share of their support from hospitals than other Internal Medicine fellowships. Given the growing fears, and in some cases the reality of declining revenues, a hospital director would likely be accused of poor business judgement if funds were diverted from a revenue enhancing program such as cardiac surgery training to a geriatrics program. Not only do programs in geriatric medicine attract patients who are likely to have longer than average stays in the hospital but as we noted before the programs themselves are not likely to be self-suffient from clinical income.

Taken together the preceeding factors make it very unlikely that funding for new faculty, or for fellowship training in geriatrics will be forthcoming unless there is action by Congress. I would like to thank you for this opportunity to speak before you and would be pleased to respond to your questions.

THE
GEORGE
WASHINGTON
UNIVERSITY
MEDICAL CENTER

Division of Geriatric Medicine

1229 25th Street, N.W. / Washington, D.C. 20037 / (202) 676-4731

July 10, 1986

The Honorable Charles E. Grassley
Chairman, Subcommittee on Aging
Committee on Labor and Human Resources
United States Senate
Dirksen Senate Office Building, Rm. 428
Washington, D.C. 20510

ATTN: Penny Bogas

Dear Senator Grassley:

I am very pleased to respond to the question which you submitted to me concerning my testimony at the June 26 hearing on "Geriatric and Gerontological Education and Training". The question which you posed was, "Explain to me in somewhat more concrete terms how improved geriatric training would help physicians make more cost-effective decisions about the care of the elderly".

As you have noted, evidence from several studies cited in my written statement show that physicians using geriatric assessment techniques can reduce the overall costs and improve outcomes in the care of the frail elderly in a variety of settings. Settings included acute hospital care, rehabilitation hospital care, home care and office space care. While the reasons for the lower costs and better outcomes have not been studied in detail, the following factors would appear to be important:

1) A careful geriatric assessment can uncover problems and diseases that are reversible, often with relatively simple, inexpensive interventions.

2) Geriatric assessment focuses on functional status, as well as disease diagnosis. Thorough knowledge of a patient's function allows services to be matched closely with needs.

3) Close linkage of medical assessment by the physician with social and nursing assessment, which is the hallmark of geriatric care, allows coordinated planning of care. This coordinated planning is something which does not always occur when separate social agencies, nursing agencies, physicians and hospitals are involved in the care.

4) Geriatric assessment frequently includes family and friends of the patient in the process. This inclusion often increases the understanding of the family or friends about the problems of the older individual and often enhances their willingness to participate in the care.

5) Physicians are often the only professionals who follow the patient through all care settings (home care, hospital care, or nursing home care). Therefore, physicians with a good working knowledge of the treatment options available for the elderly in each of these settings can help ensure the efficient and effective use of each setting.

6) Physicians with a knowledge of geriatric medicine can provide the elderly patient who may require major diagnostic or therapeutic interventions with a balanced and knowledgeable assessment of both the benefits and the risks of such interventions. For example, a number of studies done by geriatricians have shown that discontinuing certain medications in older persons can not only save the cost of the drug but reduce the level of functional disability in certain instances.

It is our strong belief that the knowledge and skills which can help ensure cost-effective care for the elderly can be imparted through improved geriatric training. As noted, it is our hope that such training would extend through the development of geriatric faculty and fellowships at medical centers to the training of all physicians who participate in the care of the elderly.

Sincerely,

L. Gregory Lawson, M.D., M.P.H.
Director, Center for Aging Studies and Services, George Washington University
Executive Board, American Geriatrics Society

LGP/de

Senator MATSUNAGA. Ms. Guzman.

Ms. GUZMAN. Thank you, Mr. Chairman.

I too have submitted longer testimony and would like that written testimony entered for the record.

Senator MATSUNAGA. That will appear in the record.

Ms. GUZMAN. Thank you.

I am very pleased to have the opportunity to speak before this Senate Subcommittee on Aging. Having formerly served as the director of the Aging and Health Program at the John A. Hartford Foundation in New York City, I am currently working as a consultant with many of the national foundations to help design their grants programs addressing the needs of the elderly and to coordinate efforts among foundations that share common interests in the area of aging. One of these common areas of interest and concern among foundations is the development of training opportunities for physicians in geriatric medicine.

I wish to share with you today my experiences gained in developing and administering the Hartford Geriatric Faculty Development Awards program as well as my perspective gleaned from discussion with other foundations as they consider ways to address the need for physician training in geriatrics.

The Hartford Geriatric Faculty Development Awards program was established by the Hartford Foundation in 1983 to help medical schools strengthen geriatric training through faculty fellowships. The vehicle selected by the Hartford Foundation to meet this objective is to train academic physicians who have reached a senior level of academic rank and leadership in their medical schools and can therefore, following a year of training, be instrumental in building a research, clinical and educational program in geriatrics at their respective medical schools.

The key concept underlying the Hartford Program is one of midcareer retraining. The program is intended to attract senior-level academic physicians with backgrounds and training in areas related to geriatrics, such as internal medicine and family practice, and who have stated an intent to redirect their area of concentration to the field of geriatric medicine.

Following a year of retraining, these physicians are expected to return to their respective medical schools committed to building academic programs in geriatrics.

The goal of the Hartford Foundation program is to develop a cadre of academically based physicians knowledgeable in the delivery of medical care to older persons, so that they, in turn can teach and train others in the field of geriatrics.

To date, there have been 23 Faculty Development Awards granted, with approximately eight physicians trained per year.

Experience with the Hartford Program to date indicates that, while this midcareer focus is an important and necessary one, a long-term solution to the problem of geriatric training requires that these midcareer physicians have a critical mass of additional physicians trained in geriatrics to assist and support them in their efforts to build and sustain geriatric research, clinical, and teaching programs at their home institutions.

The proposed bill addresses this key issue of the multiple tiers of physicians who need to be trained in geriatric medicine. Without a

critical mass of physicians at any one medical school, the efforts of a single trained physician are likely to be diffused as he or she attempts to build a geriatrics program.

Thus, while the Hartford Foundation has chosen one vehicle,the mid-career retraining, to begin to address this critical need for physician training in geriatrics, it is a short-term solution. One-person teaching units are not viable for more than a short time. We know that for a long-term effect, we will need to provide training opportunities at all levels of graduate medical education.

In addition to the Hartford Foundation, there are several other foundations that are beginning to address the need for geriatric training. The Brookdale Foundation in New York City recently launched a national fellowship program designed to encourage innovative research in the aging field. The Brookdale Fellowship Awards are targeted toward candidates, both M.D.s and Ph.D.s who have reached a stage in their careers where they have demonstrated that they are capable of outstanding work, but need protected time, freedom from their routine commitments to pursue their research interests.

The Charles A. Dana Foundation in New York City is currently developing a program to provide training opportunities in geriatrics. One aspect of this program will be aimed at training clinical investigators in the field of aging. A prototype project was recently funded at Harvard and its clinical affiliates to create a research and training unit focused on the aging syndromes such as acute confusional states and urinary incontinence. In addition to supporting research studies, this project will also train two fellows in the clinical aspects of diagnosing and treating aging syndromes.

The Dana Foundation also provides funds through the American Federation for Aging Research to support 5 new investigator awards each year and to support 12 awards each year for third- and fourth-year medical students to participate in a 1-month clinical rotation in geriatrics.

There are several other foundations as well that have acknowledged the critical need to improve the training of physicians in geriatrics. However, no single foundation nor even a pooling of all of these foundation resources can fill the gap in the numbers of physicians who will need to be trained in order to care for the increasing numbers of older patients in the population. The need for geriatric training—and consequent cost—far exceed the capacity of foundations to respond.

Foundation support in this area is critical in terms of stimulating pockets of research and training activity, whether it be through the vehicle of the midcareer training sponsored by the Hartford Foundation, or through the creation of research and training units as sponsored by the Dana Foundation.

However, these efforts must be encouraged to multiply and grow at a much faster pace in order to meet the huge demand for physicians who are knowledgeable and trained in geriatrics.

The key element to expanding these training efforts is embodied in the proposed bill. The Geriatric Physicians Graduate Medical Education Act of 1986 is intended to train physicians who plan to teach geriatric medicine.

The Hartford Foundation is currently the only foundation that supports the training of faculty through its approach of midcareer retraining. However, the Hartford Program only produces a maximum of eight trained physicians per year.

The Brookdale and Dana Foundation programs provide fellowship support for research and clinical pursuits in specific areas of geriatric medicine.

The proposed legislation represents an important step toward insuring that there will be adequate numbers of faculty to teach others in the critical areas of geriatrics. The two avenues of support outlined in the bill, a 1-year retraining program for faculty in departments of internal medicine, family medicine and psychiatry, and a 2-year internal medicine or family medicine fellowship program with emphasis in geriatrics, will move us much closer to the desired goal of having a critical mass of faculty in any one institution capable of teaching and training others in the field of geriatrics.

Thank you.

[The prepared statement of Ms. Guzman follows:]

Ina G. Guzman
Testimony Re: Geriatric Physicians
Graduate Medical Education
Act of 1986
June 26, 1986

Mr. Chairman, I am very pleased to have the opportunity to speak before this Senate Subcommittee on Aging. Having formerly served as the director of the Aging and Health program at the John A. Hartford Foundation in New York City, I am currently working as a consultant with many of the national foundations to help design their grants programs addressing the needs of the elderly and to coordinate efforts among foundations that share common interests in the area of aging. One of these common areas of interest and concern among foundations is the development of training opportunities for physicians in geriatric medicine.

I wish to share with you today my experiences gained in developing and administering the Hartford Geriatric Faculty Development Awards program as well as my perspective gleaned from discussion with other foundations as they consider ways to address the need for physician training in geriatrics.

You have already heard estimates of the numbers of physicians who must be trained in geriatrics. While it is difficult to pinpoint an exact estimate of need, it is clear that we are still far short of the projections. This shortage of physicians trained in geriatrics affects all aspects of the health care system and its ability to meet the needs of the elderly. Without more geriatricians, only limited progress can be expected in efforts: i)to improve training for medical students and practicing physicians in the diagnosis and treatment of older patients; ii)to expand medical research on aging-related problems; and iii)to improve health services for the elderly.

Many of the nation's medical schools are attempting to respond to this shortage by creating departments or divisions of geriatrics. Others have developed fellowship training programs for post-residency medical students. These efforts have, in large part, been frustrated by a lack of fully trained academic geriatricians to staff the programs and by the severe economic crisis affecting most teaching hospitals.

The Hartford Geriatric Faculty Development Awards program was established by the Hartford Foundation in 1983 to help medical schools strengthen geriatric training through faculty fellowships. The vehicle selected by the Hartford Foundation to meet this objective is to train academic physicians who have reached a senior level of academic rank and leadership in their medical schools and can therefore, following a year of training, be instrumental in building a research, clinical, and educational program in geriatrics at their respective medical schools. The key concept underlying the Hartford program is one of mid-career training. The program is intended to attract senior level academic physicians with backgrounds and training in areas related to geriatrics, such as internal medicine and family practice, and who have stated an intent to redirect their area of concentration to the field of geriatric medicine.

Following a year of re-training at one of four training sites: Harvard Medical School, Johns Hopkins School of Medicine, Mt. Sinai School of Medicine, and UCLA School of Medicine, the trained physicians are expected to return to their respective medical schools, committed to building academic programs in geriatrics. The goal of the Hartford Foundation program is to develop a cadre of academically-based physicians knowledgeable in the delivery of medical care to older persons, so that they, in turn can teach and train others in the field of geriatrics.

To date, there have been 23 Faculty Development Awards granted, with approximately 8 physicians trained per year.

Each award provides up to $50,000 for one year of partial salary support and a $5,000 relocation allowance.

Experience with the Hartford Geriatric Faculty Development Awards program to date indicates that, while the mid-career focus is an important and necessary one, a long-term solution to the problem of geriatric training requires that these mid-career physicians have a critical mass of additional physicians trained in geriatrics to assist and support them in their efforts to build and sustain geriatric research, clinical, and teaching programs at their home institutions.

The proposed bill addresses this key issue of the multiple tiers of physicians who need to be trained in geriatric medicine. Without a critical mass of physicians at any one medical school, the efforts of a single trained physician are likely to be diffused as he or she attempts to build a program adequate in the research, clinical, and teaching aspects of geriatrics.

Thus, while the Hartford Foundation has chosen one vehicle, the mid-career training, to begin to address the critical need for physician training in geriatrics, it is a short-term solution. One-person teaching units are not viable for more than a short time. We know that for a long-term effect we will need to provide training opportunities at all levels of graduate medical education.

In addition to the Hartford Foundation, there are several other foundations that are beginning to address the need for the development of the clinician/researcher/teacher in geriatric medicine. The Brookdale Foundation in New York City recently launched a national fellowship program designed to develop future leaders in geriatrics and to encourage innovative research in the aging field. The Brookdale Foundation Fellowship awards are targeted toward candidates, both M.D.s and Ph.D.s who have reached a stage in their careers when they have demonstrated that they are capable of outstanding work,

but need freedom from routine commitments to pursue their research interests. Approximately four fellows are selected each year and are supported for a two-year period at an amount up to $50,000 a year.

The Charles A. Dana Foundation in New York City is currently developing a program to provide training opportunities in geriatrics. One aspect of this program will be aimed at training clinical investigators in the field of aging. A prototype project was recently funded at Harvard University and its clinical affiliates to create a research and training unit focused on the "aging syndromes" such as acute confusional states and urinary incontinence. In addition to supporting research studies, this project will also train two fellows in the clinical aspects of diagnosing and treating aging syndromes.

The Dana Foundation also provides funds through the American Federation for Aging Research to support five "new investigator" awards each year at $25,000 per award, and to support 12 awards each year for third and fourth year medical students to participate in a one-month clinical rotation in geriatrics.

There are several other foundations as well that have acknowledged the critical need to improve the training of physicians who conduct research in aging, who diagnose and treat older patients, and who teach other physicians in the care of older patients. However, no single foundation nor even a pooling of all of these foundation resources can fill the gap in the numbers of physicians who will need to be trained in order to care for the increasing numbers of older patients in the population. The need for geriatric training (and consequent cost) far exceed the capacity of foundations to respond.

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whether it be through the vehicle of the mid-career training sponsored by the Hartford Foundation, or through the creation of research and training units as sponsored by the Dana Foundation. However, these efforts must be encouraged to multiply and grow at a much faster pace in order to meet the huge demand for physicians who are knowledgeable and trained in geriatrics.

The key element to expanding these training efforts is embodied in the proposed bill. The "Geriatric Physicians Graduate Medical Education Act of 1986" is intended to train physicians who plan to teach geriatric medicine.

The Hartford Foundation is currently the only foundation that supports the training of faculty through its approach of mid-career retraining. However, the Hartford program only produces eight trained physicians per year. The Brookdale and Dana Foundation programs provide fellowship support for research and clinical pursuits in specific areas of geriatric medicine.

The proposed legislation represents an important step toward insuring that there will be adequate numbers of faculty to teach others in the critical areas of geriatrics. The two avenues of support outlined in the bill, a one-year retraining program for faculty in departments of internal medicine, family medicine and psychiatry, and a two-year internal medicine or family medicine fellowship program with emphasis in geriatrics, will move us much closer to the desired goal of having a critical mass of faculty in any one institution capable of teaching and training others in the field of geriatrics.

Thank you for your attention.

Senator MATSUNAGA. Thank you very much, Dr. Pawlson and Ms. Guzman.

At this point, are you able to determine what the most prevalent illnesses or diseases are among the elderly?

Dr. PAWLSON. I think that we are just at the beginning of our understanding of that. There are a number of surveys that have been conducted by the National Center for Health Statistics, National Center for Health Services Research and the National Institutes of Health that are now beginning just to provide us with information about our elderly population.

It is interesting that in years past, if you were over 65 or especially over 70, you were not part most epidemiolosial studies. It was thought to be too difficult or not important. So we are just beginning to sort of gather the kind of real data we need to look at not only the things that cause death, but the things that cause the major functional problems that elderly people experience.

Senator MATSUNAGA. Alzheimer's disease, for example. You never heard about Alzheimer's a few years ago, and now you hear Alzheimer's disease, Alzheimer's disease. Do we really know how to cope with it?

Dr. PAWLSON. I think we are in many ways in long-term care and in geriatrics, where the rest of the world was 30 or 40 years ago, in beginning to kind of understand many diseases. I think Alzheimer's occurred in the wrong place. If it would have occurred in the hospital setting, we probably would know a lot more about it now. But it was hidden away in the nursing home and at home, and we are just beginning to get at diseases that seem to have their major impact in those settings.

And in terms of being able to either help in a meaningful way victims of Alzheimer's disease in terms of their care, we are just on the cutting edge; in terms of trying to cure the disease, we are still lost in the forest.

Senator MATSUNAGA. I will be 70 before too long, in a few months, and according to statistics, while in Washington, DC, I am living on borrowed time; life expectancy here is 67.2. In Hawaii, I still have a few years to go; it is 77.6 years there, I think.

Now, since I am getting to that age, I find more and more that perhaps my father was right. At age 82, people used to guess his age to be 60. He had jet-black hair, and because he was judo instructor, he was in good physical condition, and people used to ask him what his secret was.

He used to recite an old Japanese proverb: "A soul completely immersed in one's work reflects a youthful face." And I have been following that teaching of his; but then, I may not know the symptoms of Alzheimer's disease.

What are the principal symptoms? How do you begin to know you are being overcome by Alzheimer's disease?

Dr. PAWLSON. It is a very difficult disease to diagnose because we really do not have any way short of a brain biopsy—which is practically impossible to do except at autopsy—to make a absolutly certain diagnosis.

Clearly, the problems of memory loss, and especially recent memory loss, are one of the first signs. The problem is that we all forget. I always tell my elderly patients, "You know, when you are

75 and you forget something, and think you have Alzheimer's. I forget things all the time, and on one has suggested that I have that disease."

But the symptoms of marked recent memory loss, difficulty in judgment, progressing to some behavioral problems, lack of recognition of one's surroundings and so on, are some of the signs of Alzheimer's disease. But as I said, we do not really have a way of sorting the stage of Alzheimer's from the forgetfulness that all of us have from time to time.

Senator MATSUNAGA. Well, I wish to thank you all for being so patient with the subcommittee and for presenting such educational testimonies. I am sure other members of the subcommittee will read your testimonies and be influenced by what you have to say today in acting upon the bill pending before the subcommittee.

Thank you very much.

[Additional material supplied for the record follows:]

AMERICAN ASSOCIATION OF DENTAL SCHOOLS
1619 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D.C. 20036
202/667-9433

August 1, 1986

The Honorable Charles E. Grassley
Chairman
Subcommittee on Aging
Committee on Labor and Human Resources
United States Senate
SH-404 Hart Senate Office Building
Washington, DC 20510

Dear Mr. Chairman:

On behalf of our members, I thank you for this opportunity to present the views of the American Association of Dental Schools (AADS) on S. 2489, the Geriatric Physicians Graduate Medical Education Act of 1986.

The AADS represents all sixty dental schools in the United States, along with a variety of advanced education, hospital-based, and auxiliary dental education programs. We are the only national association exclusively concerned with issues affecting dental education.

The introduction of this legislation is a welcome response to the demand for specialized care of this country's elderly. As the demographics of our population change, health care professionals need special training to take care of the needs of our older citizens.

Of the 250,000 practicing physicians in the United States, there are approximately 700 trained in geriatrics. By contrast, of the 127,000 practicing dentists in our country, there are only a few, perhaps twenty, formally trained in geriatric dentistry. There are simply not enough dentists with training in geriatrics to meet the patient demand for such services, which is as pressing for dentistry as it is for medicine.

S. 2489 would amend Section 788 of Title VII of the Public Health Service Act to authorize additional funding for training physicians who plan to teach geriatrics. Many varied programs are authorized in Section 788, however, most of the appropriated funds have been awarded to Geriatric Education Centers, which are multidisciplinary training centers aimed at training health professionals in geriatrics. There are currently twenty centers in operation nationwide. Although they are highly successful, their impact on the overall need for their services is negligible.

As the elderly population increases, more people aged 65 and over will be seeking dental care. More of them will have retained their teeth through preventive programs, and they will be more educated with a higher awareness of their dental requirements. They will demand care, but they will have special needs. As with medicine, improper dental treatment or lack of dental services can be deadly. This applies most strikingly to medically-compromised patients, the bedridden, or those confined to long-term care facilities, who have chronic health problems that demand special dental treatment available only from specially-trained practitioners. Even among the "well elderly", there will be a greater incidence of oral disease, such as periodontitis and oral cancer. The relationship between functional dentition, the digestive process, and nutrition, and the interaction with prescription drugs and medical procedures is of utmost importance to many of these citizens.

While current programs, including the Section 788 Geriatric Education Centers and the V.A. Geriatric Fellowships, have attempted to address training in geriatric education, not enough attention has been devoted to training a sufficient number of geriatric dentists. Thus, the Association recommends that S. 2489 be amended to include dentistry in its proposed authorization of new, targeted funds for education and training grants in geriatrics. Providing grants for dental schools and hospital-based and other graduate dental education programs is a necessary first step to establish geriatric dentistry as an integral component of dental school curricula and postgraduate education.

We would be happy to answer questions you may have regarding this statement, and to provide you with any additional information you may need concerning our position.

We thank you again for the opportunity to present our views on this very important issue, and respectively request that these comments be included in the formal hearing record on this legislation.

Sincerely,

Richard D. Mumma, Jr.

Richard D. Mumma, Jr.
Executive Director

TESTIMONY OF

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Offered by Leonard D. Goodstein, Ph.D.
Executive Officer

before the

UNITED STATES SENATE

COMMITTEE ON LABOR AND HUMAN RESOURCES
SUBCOMMITTEE ON AGING

on the subject of

GERIATRIC AND GERONTOLOGICAL EDUCATION AND TRAINING

June 1986

Honorable Charles E. Grassley, Chair

The American Psychological Association (APA), on behalf of our 87,000 members, is pleased to present this statement for the record of the Subcommittee's hearing on "Geriatric and Gerontological Education and Training." We commend Chairman Grassley and the members of the Subcommittee for their commitment to this important issue.

We wish to address our comments to the Geriatric Physicians Graduate Medical Education Act of 1986, S. 2489.

S. 2489

The proposed legislation addresses the critical shortage of physicians trained to treat the physical health care problems of older persons by retraining certain medical school faculty members and by a geriatric fellowship program for medical students. This shortage has been well-documented by the Rand Corporation, the Administration on Aging, and by the testimony presented before this Subcommittee by Dr. John C. Beck.

We are pleased with this general effort. However, the APA is concerned that only medical school physician faculty will be eligible for retraining in geriatrics under S. 2489. Medical school faculty members who are psychologists will not be eligible for the retraining effort proposed by S. 2489. We view this as an unfortunate oversight that may have serious future implications for high-quality health care for older persons in this country.

The APA believes it is important to bring to the attention of the Subcommittee the role that psychologists have played in the training of physicians. Psychologists have held faculty appointments in medical schools for over sixty years and have served as deans of medical schools, chairs and acting chairs of departments of psychiatry, medical psychology, and behavioral sciences. There are currently over 1,800 psychologists employed in medical schools, the majority of which hold clinical/teaching positions. Almost one-half of these faculty appointments are to departments other than psychiatry, such as departments of family medicine, internal medicine, and neurology. Psychology is the only nonphysician health profession to hold clinical teaching positions comparable in responsibility and duties to physician faculty.

Psychologists contribute an understanding of the developmental process, the etiology and treatment of mental and nervous disorders, diagnostic and assessment skills, knowledge of the psychological components of physical illness and the efficacy of behavioral medicine, and the use of emotional and behavioral treatments.

Though many of the psychology faculty in medical schools have some training in geriatrics, many do not. They share with their physician colleagues the need for continuing education and retraining in geriatrics.

Fortunately, the majority of our aged population enjoys good health and independence, but a number of disorders afflict older people which can result in disability and institutionalization. Mental health disorders

occur with greater frequency among the elderly than in the non-aged adult population. These conditions often accompany other functional disabilities such as incontinence and osteoporosis, various chronic conditions, malnutrition, and neurological disorders such as Alzheimer's disease.

Research conducted by the National Institute on Aging, the National Institute of Mental Health, the Veterans Administration, and others, indicates that dysphoria and major depressive disorders are significant problems among some elderly; that many persons with long-term chronic mental disorders and those with developmental disabilities are now living into old age -- with some joining the ranks of the homeless or being "lost" in nursing homes; that the elderly have a high rate of suicide -- with men over the age of 75 having the highest rate of suicide of all age groups -- both young and old; and that alcohol abuse, polydrug use, and misuse of (or confusion about) prescription drugs are all serious problems among the aged. Psychologists are central to all these issues.

Physician are now the first, and often only, entry point for both health and mental health services for the aged in this country. It is essential that medical students be educated by faculty trained in geriatrics. Psychologists, as active already members of the teaching faculty of medical schools, should be included in faculty retraining programs.

We know that psychology is currently not included in Section 701(4) of the Public Health Service Act (Title VII), the health professions eligible for grants under Section 788, which S. 2489 amends. However, Section 701(14) of the Act specifically does define psychology, and was created, in 1985, to establish psychology as eligible for the Health Careers Opportunity Program (H-COP).

The APA urges the Subcommittee to include psychology directly in the 701(4) list, or, alternatively, to include Section 701(14) for the purposes of S. 2489, the geriatrics training initiative.

We thank the Subcommittee for the opportunity to express our views on this important proposed legislation. The APA will continue to support this Subcommittee's efforts to improve the health care of this nation's elderly.

Senator MATSUNAGA. I do have an opening statement for inclusion in the record.

We are adjourned.

[Whereupon, at 3:45 p.m., the subcommittee was adjourned.]

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